

HEALTH COMMITTEE

Fifth Report

**THE REGULATION OF PRIVATE AND
OTHER INDEPENDENT HEALTHCARE**

Volume II

Minutes of Evidence and Appendices

*Ordered by The House of Commons to be printed
12 July 1999*

LONDON: THE STATIONERY OFFICE
£33.50



22501132306

HEALTH COMMITTEE

WELLCOME TRUST INFORMATION SERVICE

25 AUG 1999

ACC. No.

15590

CLASS:

PQ Nov/C

Fifth Report

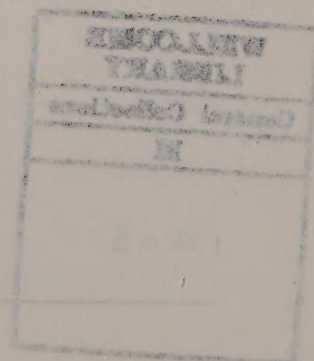
**THE REGULATION OF PRIVATE AND
OTHER INDEPENDENT HEALTHCARE**

Volume II

Minutes of Evidence and Appendices

*Ordered by The House of Commons to be printed
12 July 1999*

LONDON: THE STATIONERY OFFICE
£33.50



The Health Committee is appointed under Standing Order No. 152 to examine the expenditure, administration and policy of the Department of Health and associated public bodies.

The Committee consists of 11 Members. It has a quorum of three. Unless the House otherwise orders, all Members nominated to a committee appointed under this order shall continue to be members of that committee for the remainder of the Parliament.

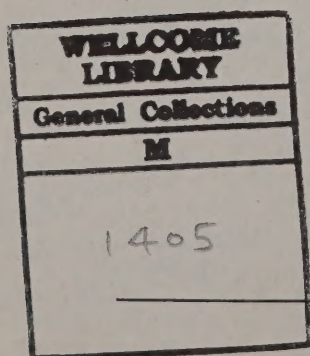
The Committee has power;

- (a) to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;
- (b) to appoint specialist advisers either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference;
- (c) to communicate to any other committee appointed under the same Standing Order (and to the European Scrutiny Committee, to the Committee of Public Accounts, to the Deregulation Committee and to the Environmental Audit Committee) its evidence and any other documents relating to matters of common interest; and
- (d) to meet concurrently with any other such committee or with the European Scrutiny Committee or any sub-committee therefore for the purposes of deliberating, taking evidence, or (in the case of any other such committee), considering draft reports.

The membership of the Committee since its nomination on 14 July 1997 has been as follows:

Mr David Amess (*added 20 July 1998*)
Mr John Austin
Dr Peter Brand
Mr Peter Brooke (*discharged 21 July 1997*)
Mr Simon Burns (*added 5 July 1999*)
Julia Drown
Mr John Gunnell
Mr David Hinchliffe
Ann Keen (*discharged 1 February 1999*)
Mr Andrew Lansley (*discharged 20 July 1998*)
Mr Ivan Lewis (*added 1 February 1999*)
Dr Howard Stoate
Mr Robert Syms
Mr Robert Walter (*added 21 July 1997, discharged 5 July 1999*)
Audrey Wise

Mr David Hinchliffe was elected Chairman on 17 July 1997.



LIST OF WITNESSES*Thursday 25 February 1999*

	<i>Page</i>
DEPARTMENT OF HEALTH	
Mr M Staniforth, Mr S Mitchell, Mr M Brown and Mr R Heron	10
NHS CONFEDERATION	
Miss C Perry	10
NATIONAL NURSING HOMES REGULATION AND INSPECTION ADVISORY GROUP	
Mrs J Morton	10

Thursday 4 March 1999

THE CONSUMERS' ASSOCIATION	
Ms C MacKay and Ms S Williams	38
NATIONAL CONSUMER COUNCIL	
Ms J Johnstone and Ms B Meredith	38
ACTION FOR THE PROPER REGULATION OF PRIVATE HOSPITALS	
Mr J Lambie, Mrs C Buckley, Ms S Ryb and Mr G Maloney	74
ACTION FOR VICTIMS OF MEDICAL ACCIDENTS	
Mr A Simanowitz, Ms L Thomas and Dr J Hines	74

Thursday 25 March 1999

INDEPENDENT HEALTHCARE ASSOCIATION	
Mr B Hassell	131
BUPA HOSPITALS	
Dr A Vallence-Owen	131
GENERAL HEALTHCARE GROUP	
Mr C Auld	131
NUFFIELD NURSING HOMES TRUST	
Mr D Ervine	131
COMMUNITY HOSPITALS GROUP	
Mr A Pilgrim	131

Thursday 15 April 1999

INDEPENDENT HEALTHCARE ASSOCIATION

Ms C Quest	164
------------------	-----

GENERAL HEALTHCARE GROUP

Mr P Farrier	164
--------------------	-----

WESTMINSTER HEALTH CARE

Ms M Cudmore	164
--------------------	-----

PRIORY HEALTHCARE

Mr S Page	164
-----------------	-----

ST. ANDREW'S HOSPITAL, NORTHAMPTON

Dr M Harris	164
-------------------	-----

DEPARTMENT OF HEALTH

Mr M Brown	180
------------------	-----

MENTAL HEALTH ACT COMMISSION

Dr T Jerram	180
-------------------	-----

MIND

Ms M Pedler	180
-------------------	-----

ROYAL COLLEGE OF PSYCHIATRISTS

Dr R Jones	180
------------------	-----

Thursday 22 April 1999

ADVERTISING STANDARDS AUTHORITY

Mrs M Alderson	199
----------------------	-----

Mr A Mohammed	199
---------------------	-----

BRITISH ASSOCIATION OF AESTHETIC PLASTIC SURGEONS

Mr B Jones	211
------------------	-----

BRITISH ASSOCIATION OF PLASTIC SURGEONS

Mr A Leonard	211
--------------------	-----

HARLEY MEDICAL GROUP

Mr M Braham, Mr P Coles and Mrs D Hansen	230
--	-----

TRANSFORM

Mr D Cooper, Mrs E Gibbons and Mr J Pickering	230
---	-----

Thursday 29 April 1999

BRITISH MEDICAL ASSOCIATION

Mr D Machin 266

ROYAL COLLEGE OF NURSING

Ms S Taber and Ms P Gough 266

GENERAL MEDICAL COUNCIL

Sir Donald Irvine and Miss I Nisbet 292

INDEPENDENT DOCTORS FORUM

Dr G Mitchell 292

MEDICAL DEFENCE UNION

Dr C Tomkins and Mr R Hoppenbrouwers 292

PRIVATE PRACTICE FORUM OF THE ACADEMY OF MEDICAL ROYAL COLLEGES

Dr J Jay 292

Thursday 13 May 1999

DEPARTMENT OF HEALTH

Rt Hon Frank Dobson, MP, Lady Helene Hayman and Mr M Staniforth 310

LIST OF MEMORANDA INCLUDED IN THE MINUTES OF EVIDENCE

Memoranda and supplementary memoranda submitted by:

	<i>Page</i>
Department of Health [PM 77]	1
NHS Confederation and the National Nursing Homes Regulation and Inspection Advisory Group [PM 46]	5
NHS Confederation [PM 46A]	28
Department of Health [PM 77A]	28
The Consumers' Association [PM 52]	30
National Consumer Council [PM 56]	36
Action for Victims of Medical Accidents [PM 53]	51
Action for the Proper Regulation of Private Hospitals [PM 49 Annex A]	58
Mr Graham Maloney, APROP [PM 19]	71
Independent Healthcare Association [PM 58]	86
Independent Healthcare Association [PM 58A]	105
BUPA [PM 61]	107
General Healthcare Group [PM 51]	115
Nuffield Hospitals [PM 36]	123
Community Hospitals Group [PM 59]	127
Westminster Health Care [PM 73]	156
Priory Health Care [PM 27]	159
St. Andrew's Hospital, Northampton [PM 20]	160
St. Andrew's Hospital, Northampton [PM 20A]	162
Mental Health Act Commission [PM 94]	174
MIND [PM 85]	176
Royal College of Psychiatrists [PM 71]	179
Mental Health Act Commission [PM 94B]	194

St. Andrew's Hospital, Northampton [PM 20B]	194
Advertising Standards Authority [PM 14]	196
Mr A Mohammed [PM 83]	198
British Association of Aesthetic Plastic Surgeons of England [PM 30]	209
British Association of Plastic Surgeons [PM 96]	209
Transform Medical Group [PM 26]	221
Harley Medical Group [PM 55]	227
Mr A Mohammed [PM83A]	241
Harley Medical Group [PM 55A]	241
Transform Medical Group [PM 26A]	242
Advertising Standards Authority [PM 14A]	243
Mr A Mohammed [PM 83B]	244
British Medical Association [PM 41]	245
Royal College of Nursing [PM 62]	250
General Medical Council [PM 102]	278
Mr Charles Akle [PM 6]	281
Independent Doctors Forum [PM 106]	282
Medical Defence Union [PM 70]	282
Private Practice Forum [PM 68]	291
Private Practice Forum [PM 68A]	291
Royal College of Nursing [PM 62A]	306

LIST OF APPENDICES TO THE MINUTES OF EVIDENCE

Memoranda submitted by:

1. Ms Rose Irwin [PM 1B]
2. Mr Michael Miller, P7 Marketing Soulutions [PM 12]
3. Dr Sarah Myhill [PM 13]
4. Bromley Health Authority Registration and Inspection Unit [PM 15]
5. Institute of Chartered Secretaries and Administrators [PM 16]
6. Charter Europe [PM 17]
7. Mr Anthony Erian [PM 18]
8. Action for the Proper Regulation of Private Hospitals [PM 49B]
9. Advantage Healthcare [PM 21]
10. Sunderland Health Authority and Gateshead and South Tyneside Health Authority [PM 22]
11. Doctor Patient Partnership [PM 28]
12. PPP Healthcare Group [PM 29]
13. Association of Community Health Councils for England and Wales [PM 32]
14. East Kent Medical Services Ltd [PM 33]
15. South East Kent Community Health Council [PM 34]
16. Norwich Union [PM 37]
17. National Council for Hospice and Specialist Palliative Care Services [PM 39]
18. North & East Devon Health Authority [PM 40]
19. Counsel and Care for the Elderly [PM 42]
20. The Society of Chiropractors and Podiatrists [PM 43]
21. Sinclair Montrose Healthcare plc [PM 45]
22. The King's Fund [PM 47]
23. Royal College of Paediatrics and Child Health [PM 48]
24. PPP/Columbia Healthcare Limited [PM 50]

-
25. Mrs Caroline Buckley [PM 54]
 26. British Dental Association [PM 57]
 27. Association of Directors of Social Services [PM 60]
 28. The Relatives Association [PM 63]
 29. The Chartered Society of Physiotherapy [PM 64]
 30. Mr A J Darley-Jones [PM 65]
 31. Prime Health [PM 66]
 32. Changing Faces [PM 69]
 33. Mr G D R Martin [PM 72]
 34. Capsticks Solicitors [PM 75]
 35. Carole Monterio-D'Aguiar [PM 76]
 36. United Kingdom Central Council for Nursing, Midwifery and Health Visiting [PM 78]
 37. The Health Quality Service [PM 82]
 38. The Heart Hospital (Gleneagles Hospital (UK) Limited) [PM 87]
 39. Mr Arie Carmon [PM 90]
 40. Hospital Consultants and Specialists Association [PM 91]
 41. Mr Alasdair Short [PM 93]
 42. MACA [PM 99]
 43. British Association of Cosmetic Surgeons [PM 101]
 44. The Advertising Association [PM 103]
 45. National Nursing Homes Registration and Inspection Advisory Group [PM 105]
 46. Human Fertilisation and Embryology Authority [PM 107]
 47. Lord Borrie Q.C. [PM 108]
 48. Health Service Commissioner for England [PM 109]
 49. British Orthopaedic Association [PM 110]
 50. Association of Anaesthetists of Great Britain and Ireland [PM 111]

- 51. London Consultants' Association [PM 114]
- 52. BUPA [PM 61A]
- 53. Nuffields Hospitals [PM 36A]
- 54. Capsticks Solicitors [PM 75A]
- 55. General Healthcare Group [PM 51A]
- 56. Department of Health [PM 77B]
- 57. Mr Chris Vellenoweth [PM 118]
- 58. Department of Health [PM 77C]
- 59. Mrs Elaine Isaccs [PM 35]

LIST OF MEMORANDA REPORTED TO THE HOUSE BUT NOT PRINTED

The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Record Office, House of Lords, and are available to public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London, SW1 (tel 020 7219 3074). Hours of inspection are from 9.30 am to 5.00 pm on Mondays to Fridays.

Memoranda or supplementary memoranda submitted by:

Ms Rose Irwin [PM1, 1A, 1C]

Dr P B James [PM 2]

Professor R F Barry [PM 3]

McGhan Limited [PM 4]

Ms Susan Green [PM 5]

Professor E P Goldberg [PM 7]

Mr John Lambie [PM 8]

Ms Margo Cameron [PM 9]

Bromley Health Authority [PM 10]

Ben – Motor and Allied Trades Benevolent Fund [PM 11]

Dr Sarah Myhill [PM 13A]

Mr Graham Maloney [PM 19B]

Sunderland, Gateshead & South Tyneside Health Authorities* [PM 22]

The Federation of Ophthalmic and Dispensing Opticians [PM 23]

General Optical Council [PM 24]

Denplan Limited [PM 25]

Association of Surgeons of Great Britain and Ireland [PM 31]

Mrs Elaine Isaacs [PM 35A]

Mr R Ennals [PM 44]

Action for the Proper Regulation of Private Hospitals [PM 49A]

Action for the Victims of Medical Accidents [PM 53A]

Independent Healthcare Association [PM 58B]

Royal College of Nursing [PM 62B]

Changing Faces [PM 69A]

Faculty of Occupational Medicine of the Royal College of Physicians [PM 74]

British Geriatrics Society [PM 79]

General Osteopathic Council [PM 80]

The Royal College of Anaesthetists [PM 81]

Mrs J L Holgate [PM 84]

Marie Curie Cancer Care [PM 86]

Mrs L Zaffern [PM 88]

Mrs Elizabetta Gissara [PM 97]

Mrs Eileen Jackson [PM 89, 89A]

Laserase [PM 92]

Crown Eyeglass plc [PM 95]

Nestor Healthcare Group plc [PM 98]

Citizens Commission on Human Rights [PM 100]

British Association of Otorhinolaryngologists [PM 104]

National Nursing Homes Registration and Inspection Advisory Group* [PM 105]

Adverse Psychiatric Reactions Information Link [PM 112]

Mr George Joss [PM 113]

London Consultants Association [PM 114]

Mr P H Ashby [PM 115]

Highgate Private Hospital [PM 116]

Radio Advertising Clearance Centre [PM 117]

* Annexes only

MINUTES OF EVIDENCE

TAKEN BEFORE THE HEALTH COMMITTEE

THURSDAY 25 FEBRUARY 1999

Members present:

Mr David Hinchliffe, in the Chair

Mr David Amess
Mr John Austin
Julia Drown
Mr John Gunnell

Mr Ivan Lewis
Dr Howard Stoate
Mr Robert Syms

Memorandum by the Department of Health

REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 77)

This memorandum is submitted in response to an invitation by the Health Committee for the Department of Health to submit evidence on their terms of reference:

To examine the adequacy and extent of the regulation, monitoring and inspection of healthcare outside the NHS. The Committee will also take evidence on complaints procedures relating to such provision.

1. INTRODUCTION

1.1 This memorandum of evidence provides information on:

- The non-NHS healthcare sector;
- The current arrangements for regulating and inspecting private and other independent healthcare provision;
- The complaints procedure for such provision.

It does not give information on the regulation of residential and nursing home care on which the Government has set out its plans for improving regulatory arrangements in the White Paper “Modernising Social Services” published in November 1998.

2. THE NON-NHS HEALTHCARE SECTOR

2.1 This section looks at the non-NHS healthcare sector.

Primary Care

2.2 General Medical and Dental Practitioners (GPs and GDPs) can and do undertake work outside the NHS but the arrangements for doing so vary between the professions.

2.3 GPs contract with a Health Authority and are bound by the terms and conditions of service in the General Medical Services (GMS) regulations. The GP contract provides that full-time GPs are personally to provide general medical services during not less than 26 hours in any week for 42 weeks in a year and normally over 5 days. The hours must also be allocated over the 5 days in a manner likely to be convenient to patients. Outside this GPs can, and have always been able to, take on private patients. The numbers of wholly private patients GPs deal with are not large—if patients choose to see a GP privately they do not usually de-register with the NHS—and similarly there are few GPs running wholly private practices. Patients may choose to see a GP from outside their NHS practice privately for a second opinion.

2.4 The Statement of Fees and Allowances for GPs recognise that some GPs have private patients, and reimbursement of staff and surgery costs, grants for IM&T and other reimbursements may be abated. No abatement takes place where private practice forms less than 10 per cent of total gross practice receipts. Payments are supposed to be abated pro rata where private practice accounts have higher proportions of gross practice receipts. For the years 1995–96 and 1996–97 we estimate that a little over six per cent of the average GPs gross professional income came from “non-GMS” sources. “Non-GMS” earnings include earnings from providing services to other parts of the NHS (eg work as a clinical assistant in a local hospital), fees paid by other Government departments (eg reports on fitness to drive for the Driver and Vehicle Licensing Agency (DVLA)) and Local Government (eg reports to Social Services departments in connection

*25 February 1999]**[Continued]*

with adoption) and the provision of a limited range of non-NHS services (eg religious circumcision, witnessing passport applications) to their registered patients. These data suggest that the earnings of NHS GPs from private patients are minimal.

2.5 In recent years there have been some developments in private general practice centres offering ad hoc consultations, but these services are not designed to provide continuity of healthcare, nor is it generally advisable for patients to have advice from two GPs except in cases where information is shared.

2.6 General Dental Practitioners are free to decide the amount of time they spend working for the NHS. Accurate information is not available on the amount of time and activity which they carry out in the private sector but an estimate in 1994-95 was that private earnings accounted for 15 per cent of total earnings. Anecdotal evidence suggests that this figure may since have increased. This average conceals a wide range of activity. A small number of dentists (estimated to be no more than 1,000) work entirely in private practice. This compares with over 17,000 GPs who work wholly or in part for the NHS in England.

2.7 Most optical services are provided privately, but the proportion of NHS activity will increase from 1 April when, in addition to children, people on low incomes and people pre-disposed to eye disease, all people aged 60 and over become eligible for NHS sight tests. As a result, some 60 per cent of the 15 million sight tests conducted each year will be provided under the NHS. However, all optical appliances are bought privately, with children and people on low incomes provided with a NHS spectacle voucher which can be put towards the cost of the glasses they need.

2.8 Other primary care services such as chiropody are supplied by both the NHS and the private sector. NHS care is increasingly allocated on the basis of eligibility related to clinical need. All NHS professionals are required to be members of their professional body but this is not the case in the private sector and it is possible to practice as a chiropodist with only limited training.

Secondary Care

2.9 A limited range of secondary health care services is provided outside the NHS. In addition to hospitals providing acute medical and surgical services such provision includes:

- Psychiatric hospitals including secure units and services for people with learning disabilities;
- Rehabilitation services which can span the health and social care interface;
- Abortion services;
- Hospice care, often provided by charitable organisations;
- Cosmetic surgery.

2.10 Non-NHS secondary care providers include for profit and not for profit organisations.

2.11 At 31 March 1998, the latest date for which information is available; there were just under 400 private hospitals and clinics registered under section 23 of the registered Homes Act 1984 with a total of 11,100 beds. As at 31 March 1997, the latest date for which this information is available, private hospitals and clinics had an occupancy rate of just over 50 per cent. Some 90 per cent of available beds were in general specialties. They employed some 7,660 whole time equivalent qualified nurses and a further 1,710 whole-time equivalent other nursing staff.

2.12 The Department of Health does not collect information on total spending or activity in the private healthcare sector. Information is, however, collected on the treatment of NHS patients in the independent sector. In 1997-98 Health Authorities and GP Fundholders spent £1.08 billion on commissioning services from the independent sector, less than five per cent of total spending on commissioning services. Over half of this spending (£620 million) was on residential care and day care mainly for those with learning disabilities or mental illness. Such spending is predominantly in the non-statutory and not for profit sectors and is usually planned with, and may be delivered through, local Social Services Authorities.

2.13 Guidance was issued to the NHS in 1997 which required Health Authorities and GP Fundholders to explore the scope to make maximum cost-effective use of local NHS capacity before contemplating recourse to private sector hospital provision. There is relatively little NHS use of the non-NHS sector for general and acute work. Last year some 29,000 elective ordinary admissions and 62,000 day cases were commissioned outside the NHS in general and acute specialties (less than two per cent of total day cases and 1.5 per cent of total elective ordinary admissions). Total spending in these areas amounted to less than £100 million compared with over £10,200 million spent within the NHS.

2.14 In 1997 the independent sector undertook 49 per cent (83,731) of all abortions performed in England and Wales. Of these 44 per cent (37,731) were carried out on NHS patients under contract. There is considerable regional variation in the number of terminations carried out in the private sector under contract from the NHS. In some areas of the country, for example, the West Midlands, large numbers of clinical staff have registered a conscientious objection to performing termination of pregnancy under Section 4 of the

*25 February 1999]**[Continued]*

Abortion Act. The provisions of the conscience clause have resulted in the NHS not being able to provide a comprehensive abortion service in some areas and in significant use of contracts with the private and voluntary sector.

2.15 The NHS makes significant use of the voluntary sector to provide palliative care. Of the 171 hospice units in England, only 35 are run by the NHS and the NHS manages only 17.5 per cent of all specialist palliative care beds in England. In most cases Health Authorities pay substantially less than the full cost of palliative care provision in voluntary sector hospices, the difference being made up from voluntary funding of the hospice. Nationally the NHS pays some 33 per cent of the running costs of hospices in England.

REGULATION AND INSPECTION ARRANGEMENTS

3.1 With few exceptions independent sector hospitals and clinics have to be registered with and inspected by Health Authorities under Part II of the Registered Homes Act 1984 which classifies these services as nursing homes. The services covered include:

- Independent acute hospitals;
- Independent psychiatric hospitals (including those specialising in drug or alcohol abuse);
- Hospices for the terminally ill;
- Any premises (unless specifically excluded) where:
 - (i) surgical procedures are carried out under general or local anaesthesia;
 - (ii) pregnancies are terminated;
 - (iii) endoscopy is carried out;
 - (iv) haemodialysis or peritoneal dialysis is carried out;
 - (v) specially controlled techniques (at present the use of class 3B and class 4 lasers) are used.

The following independent healthcare premises are exempt from registration under Part II of the 1984 Act:

- Any sanatorium provided at a school or education establishment used solely by pupils and staff or their families;
- First aid or treatment rooms provided at factories, and premises to which the Offices, Shops and Railways Premises Act 1963 applies or at a sports ground, show ground or place of public entertainment;
- Premises used wholly or mainly by a medical practitioner, dentist or chiropodist for the purpose of consultation/treatment of patients or for provision of occupational health facilities unless used for provision of treatment by specially controlled techniques (ie class 3B and 4 lasers);
- Premises used wholly or mainly as private dwellings.

3.2 Health Authorities must inspect each facility registered with them at least twice a year and be satisfied that the statutory requirements and any local conditions for registration are being met. Inspections may be out of hours and unannounced. The primary concern of the registering Authority is to ensure that patients are properly cared for according to their needs. Guidance issued by the National Association of Health Authorities (NAHA) in 1985, and subsequent supplements, provides advice to Authorities in their regulatory role. This guidance covers a wide range of topics but has no statutory force.

3.3 Health Authorities are entitled to charge fees for registration and inspection of premises. Currently these fees, which are set nationally, are:

- Initial registration fee £952;
- Annual per bed fee £46;
- Annual fee for premises which do not provide beds for patients to stay overnight £215.

Health Authorities are required to make publicly available the reports of their inspections of nursing homes, including private healthcare establishments.

3.4 If an establishment fails to comply with any of the statutory requirements or local requirements Health Authorities have the power to cancel or refuse registration. The Registered Homes Act specifies the grounds for such action, for example, if the person responsible for the establishment is not a fit person; if the premises are not suitable; if the establishment is used for improper or undesirable purposes; or if the staffing is inappropriate. If a registration is either refused or cancelled, or if the Health Authority imposes any conditions which the establishment's owner feels are unreasonable, the owner has a right, under Section 34 of the Registered Homes Act, to appeal to the Registered Homes Tribunal whose decisions are legally binding. If the owner does make such an appeal the Health Authority's decision to cancel the registration does not take effect until the appeal has been heard.

*25 February 1999]**[Continued]*

3.5 In an emergency, closure powers are also available through application to a magistrate. Where an emergency closure procedure is used the owner may appeal to the Registered Homes Tribunal but closure takes effect immediately and the establishment stays closed pending appeal.

3.6 Features of the current regulatory regime include:

- Health Authorities have responsibilities both for regulating independent healthcare providers and in some cases commissioning services from them;
- There are 100 Health Authorities in England with varying inspection regimes;
- The current regulatory arrangements give Health Authorities little influence on standards of care;
- Health Authorities have few powers other than to decline to register, or to de-register, an establishment and cannot, for example, require an establishment to cease undertaking particular techniques where the inspectors have concerns;
- Health Authorities have no locus to investigate complaints other than those related to conditions of registration if the service being complained about was not NHS funded;
- Some treatments are carried out in unregulated premises.

3.7 In the light of these concerns, and given the proposed changes to the regulation of care services set out in “Modernising Social Services”, the Government proposes to consult widely on the most appropriate future regulatory arrangements for the private and other independent healthcare sector and will want to take account both of the outcome of consultation, and of the Health Committee’s report and recommendations, in framing its proposals.

3.8 In addition to the requirement to be registered under the Registered Homes Act private and voluntary sector clinics or hospitals which wish to undertake termination of pregnancy must apply to the Secretary of State for approval under Section 1(3) of the Abortion Act. There are currently 78 approved clinics, 17 of which specialise in abortion services. All approved clinics and hospitals must agree to comply with a set of requirements known as The Assurances and are subject to monitoring, including unannounced inspections by Departmental officials.

3.9 The Mental Health Act Commission (MHAC) periodically visits mental nursing homes which are registered to look after patients detained under the provisions of the Mental Health Act 1983. This flows from their remit to visit any establishment where detained patients reside whether in the statutory or private sectors. Copies of visit reports are routinely submitted to the relevant regulatory authorities, and in cases where the Commission have concerns they often work closely with those authorities in pursuing them. While the MHAC is not a formal part of the reviewing process, they have written guidance notes on the use of the Mental Health Act in nursing homes. These guidance notes have been circulated to all registration authorities and to all nursing homes registered to provide care for patients detained under the Mental Health Act.

3.10 Finally, professional staff working in the private healthcare sector remain subject to professional regulation as exercised by bodies such as the General Medical Council (GMC) and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). These bodies provide guidance to practitioners on conduct and ethics and are responsible for determining allegations of unfitness to practice. The UKCC has recently highlighted the disproportionate numbers of disciplinary cases from the private sector.

3.11 The Government is aware of concerns about the relationship between the NHS and the private sector in relation to disciplinary cases and particularly that doctors who have been suspended from work by their NHS employer may continue to work in the private sector. If a hospital suspends a doctor and is concerned that he or she may seek employment elsewhere (in the NHS or private sector) and considers that this would endanger patients, an “alert letter” can be issued. In serious cases the matter can be referred to the General Medical Council straight away. The Preliminary Proceedings Committee can suspend a doctor’s registration pending the outcome of a full hearing by the Professional Conduct Committee. In these circumstances a doctor may not continue in practice.

4. COMPLAINTS

4.1 The NHS has a comprehensive complaints procedure for patients to use when they are not satisfied with the services or treatments they have received. The NHS complaints procedure covers services provided by the NHS and NHS funded care provided by the private sector. Such complaints have to be taken up with the private sector. Patients and their representatives have expressed concerns about the effectiveness of private sector procedures in some cases. In consulting on new regulatory arrangements for the private healthcare sector the Department will wish to seek views on the most appropriate way to ensure that such complaints are handled effectively.

January 1999

25 February 1999]

[Continued

**Joint memorandum by the NHS Confederation and the National Nursing Home Registration
and Inspection Advisory Group**

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 46)

INTRODUCTION

1.1 The NHS Confederation is the representative body for hospital trusts, health authorities and health boards in the UK.

1.2 The National Nursing Home Registration and Inspection Advisory Group is the representative group for Health Authority registration and inspection officers in England and Wales.

1.3 We note that the Health Committee has agreed "to examine the adequacy and extent of the regulation, monitoring and inspection of healthcare outside the NHS". This new inquiry has been established shortly following the publication of the Modernising Social Services White Paper¹. This sets out proposals for a new dependent inspection system for some parts of the private and independent healthcare sector.

1.4 This paper assumes that the proposals in the White Paper will be implemented and highlights concerns about a lack of clarity for the regulation, monitoring and inspection of those elements of the private and independent healthcare sector not covered by the proposed Commissions for Care Standards (CCS).

1.5 This paper highlights some broad issues linked to regulation, monitoring and inspection of private and independent healthcare. If required at a later date further more detailed evidence can be submitted.

2. Why regulate Private and other Independent Healthcare

2.1 Modernising Social Services refers to the importance of independent systems for protecting vulnerable people living in residential homes, nursing homes and children's homes. The White Paper stresses the importance of the individuals and their families being confident that the care they receive will be competent and safe.

2.2 In our view this principle of competent and safe services and the need to protect the vulnerable also applies to the acute and mental health private provision for which the future registration, monitoring and inspection process has not yet been determined. For example individuals accessing private abortion facilities or wishing to undergo cosmetic surgery not available through the National Health Service are equally vulnerable and need to be confident that the care and treatment on offer is competent and safe. The same principles should apply to patients admitted to hospices for terminal care.

2.3 It is also important to highlight that a significant proportion of people receiving treatment and care in the private and independent sector are placed in these services through NHS contracts and are NHS patients. For example, Health Authorities contract with private acute hospitals for the treatment of patients on NHS waiting lists, and with private secure psychiatric hospital for patients in need of long term medium secure facilities.

2.4 The principal requirement of registration and inspection in our view is to ensure competent operators who can assure the regulators and the general public that they employ adequate numbers of medical and nursing staff with the required skills, competency and experience to meet the needs of patients.

2.5 Modernising Social Services also highlights the current lack of independence with local and health authorities having to combine responsibilities for purchasing, providing and regulating services. The introduction of Commissions for Care Standards addresses the issue of independence for the nursing and residential homes sector and in our view should apply also to the acute general and mental health hospital sectors and hospices.

2.6 Patients in some independent mental health hospitals may be detained under the Mental Health Act 1993. The current review of this legislation could possibly lead to a strengthening of the Mental Health Act Commission or similar independent body to include the registration and inspection of the independent facilities. However, this may not be relevant for those patients admitted on a voluntary basis.

3. Categorisation of Private and other Independent Healthcare

3.1 There are over 200,000 registered beds in around 6,500 private and independent establishments in England and Wales².

3.2 The establishments registered are those which are contained in the categories defined in the Registered Homes Act 1984, and are detailed in Appendix 1.

25 February 1999]

[Continued

3.3 There is now a need to consider the advancement of various types of beauty therapies and alternative therapies since 1984. New therapies such as schlerotherapy and hyperbaric oxygen therapy are being provided in unregulated and unregistered establishments. Some of these therapies include minor surgical techniques and invasive procedures³.

3.4 The lack of regulation and registration also applies to practitioners such as chiropodists, psychotherapists and chiropractors. There are systems of registration with professional bodies for such practitioners but the premises from which they work are not currently regulated.

4. *Statutory Framework*

4.1 As highlighted above the Registered Homes Act 1984 is out of date. The current legislation covers all types of independent healthcare, from high technology state of the art acute hospitals, through to medium secure forensic psychiatric hospitals and converted houses for frail elderly people or people with a learning disability.

4.2 Of the 200,000+ registered beds about ninety five per cent are nursing homes and the attention to regulation has inevitably focused on this sector. A change in the legislation is therefore required to address the significant differences in the premises, facilities and staffing requirements between the categories of care.

4.3 The Registered Homes Act 1984 will have to be amended or rewritten to address the transfer of responsibilities from health and local authorities to the proposed Commissions for Care Standards.

4.4 In a Report⁴ in 1995, the predecessor body to the NHS Confederation highlighted that the current statutory position leads to very real limits to the extent to which health authority inspectors can check that care provided meets the needs of individual patients. The report noted that it is only registered medical practitioners who are empowered to inspect any clinical record relating to a patient in a registered establishment.

4.5 The absence of any reference to individual care needs is a weakness of the Act and action for an individual patient is only achieved by encouragement and negotiation.

4.6 The Act also fails to enable regulation and monitoring of the promotion of health, prevention of ill health, recuperation and rehabilitation.

4.7 If shortcomings are identified by Registration Officers, the Act offers nothing less than deregulation to address the problems.

5. *Present arrangements*

5.1 Under the Registered Homes Act 1984 it is the responsibility of individual health authorities to register, inspect and enforce standards in all registered premises. This role includes assessing fit persons, fit environment and adequate services.

5.2 Registration and Inspection Units are primarily staffed with trained nursing staff with access to professional advice from pharmacists and other specialist advisers if required. On average each whole time nurse inspector has a "caseload" of approximately 900 beds in 27 registered premises².

5.3 The range of nursing skills and expertise required to register and inspect the different categories of care detailed in Appendix 1 are principally found in the current Registration and Inspection Units.

5.4 There are other regulatory bodies with responsibilities in the regulation of private and other independent healthcare, for example:

- The Health and Safety Executive;
- Trading Standards;
- Mental Health Act Commission;
- General Nursing Council;
- General Medical Council.

6. *Funding of private and independent treatment and care*

6.1 A large percentage of patients in nursing homes are funded by social services and a smaller percentage by health authorities. The current level of that funding, particularly from social services, is not adequate enough to support the provision of anything but nursing care, and other services such as chiropody, physiotherapy, occupational therapy, speech therapy are not therefore provided.

25 February 1999]

[Continued

6.2 Health Service Guidelines⁵ issued in 1995 contained advice that services such as chiropody, physiotherapy, etc must be provided to residents in nursing homes from NHS resources where money is available. In view of the pressures on NHS budgets and prioritising of services, this funding is not normally available to provide such services in nursing homes.

7. *Impact of Commissions for Care Standards*

7.1 As highlighted earlier about 95 per cent of registered premises are nursing homes. An assessment² of Health Authority Registration and Inspection Units identified that 84 per cent of the workload of Inspection Officers is associated with nursing homes.

7.2 If this workload and the resources associated with it are transferred to the Commissions for Care Standards, this leaves the task of registration and inspection of the remaining premises non-viable for individual health authorities.

7.3 In one health authority for example there are five whole time equivalent inspectors with the following:

- 150 registered premises;
- three hospices;
- two dental clinics;
- four medical/surgical hospitals, including operating theatres;
- one forensic psychiatric hospital;
- one acute psychiatric clinic;
- one psychiatric hospital.

Once responsibility for the 138 nursing homes is transferred to the CCS there will be insufficient premises remaining to justify one whole time member of staff. Also the range of skills and expertise required to register and inspect the different categories can not be found in one person.

7.4 Some of the above premises also have elderly long term care beds as part of their registration, and these beds will come within the remit of the CCS.

7.5 Following changes in the role of Health Authorities there are now very few nursing staff employed and certainly insufficient numbers to take over the role of registering and inspecting the non-nursing home sector.

7.6 In urban and rural areas, the geographical spread of acute and mental hospital facilities would preclude the sharing of staff across a number of health authorities.

7.7 It is the view of the majority of health authorities recently surveyed, that responsibility for registration and inspection of all private and independent health care should be passed to the new Commissions for Care Standards. The skills and expertise required for this task are currently vested in health authority Registration and Inspection officers and this group of staff will need to transfer to the CCS to continue the process for nursing homes.

8. RECOMMENDATIONS

8.1 There is an urgent need to define the future responsibility for the registration and inspection process for all premises that will not become the responsibility of the Commissions for Care Standards.

8.2 A clear definition of the services and premises to be regulated by the CCS is required. Some acute medical and mental health hospitals contain long term care beds that should come within the remit of the CCS.

8.3 Any new legislation developed to replace the Registered Homes Act must take account of the recent developments in beauty and alternative therapies.

8.4 Any individual wishing to access private and other independent healthcare should be considered vulnerable and entitled to be confident that care and treatment provided is competent and safe.

REFERENCES

¹ Modernising Social Services, Department of Health 1998.

² Nursing Home Registration and Inspection Database as at 31 March 1997, The NHS Confederation July 1998.

³ Independent Acute Hospitals and services, The National Association of Health Authorities and Trusts, 1993.

25 February 1999]

[Continued]

⁴ Applying Citizen's Charter Principles to the Registration and Inspection of Independent Nursing Homes, The National Association of Health Authorities and Trusts, February 1995.

⁵ Arrangements between Health Authorities and NHS Trusts and private and voluntary sector organisations for the provision of community care services, HSG 95 (45).

APPENDIX 1

The NHS Confederation

CATEGORISATION OF NURSING HOMES: NURSING HOMES [REGISTERED HOMES ACT 1984 SECTION 21]

1. GENERAL NURSING CARE^{1,2,3}

The provision of general nursing care. The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Parts 1 or 12).

2. SPECIALIST NURSING CARE^{2,3}

The provision of nursing care to a specialist level by reason of, for example, Hospice, Specialist Palliative Care, Brain injury, Physical Disabilities, Rehabilitation, Renal dialysis or to meet the needs beyond those provided in (1) above. The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Parts 1 or 12) with additional and appropriate qualifications approved by a National Board for Nursing, Midwifery and Health Visiting.

It is likely that Professions Allied to Medicine would be included and that the level of medical care would exceed that of core General Medical Services.

3. PALLIATIVE NURSING CARE^{2,3}

The provision of general palliative care, the care of terminally ill people that can be carried out in a General Nursing Home with, where appropriate, visiting specialist palliative care. The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Parts 1 or 12). The Person in Charge or the required number of Registered Nurses will have additional and appropriate ENB/WNB qualification.

4. ACUTE HOSPITALS^{2,3}

The provision of general, medical, surgical, dental or maternity services in an independent acute hospital or clinic, including day care.

The Person in Charge must be a Registered 1st Level Nurse* on the appropriate part of the UKCC Register for the service being provided.

5. SPECIALLY CONTROLLED TECHNIQUES^{2,3}

The provision of lasers class 3b or 4 under the charge of an appropriately qualified Medical or Dental Practitioner.

6. TERMINATION OF PREGNANCY CLINICS^{2,3}

The provision of termination of pregnancy under the provisions of the Abortion Act 1967. The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Parts 1, 10, 12). There is no requirement that the registered nurse Part 10 be a "Practising Midwife".

25 February 1999]

[Continued]

7. MOTHER AND BABY HOMES^{2,3}

The provision of care for Mothers and their Babies. The home will be in the charge of a Registered Midwife (UKCC Register Part 10).

Mental Nursing Homes [Registered Homes Act 1984 Section 22]1. MENTAL HEALTH NURSING CARE^{2,3}

The provision of mental health nursing for people with a mental illness [including Alzheimer's Disease, Dementia]. The Person in Charge of the Home must be a Registered Nurse (UKCC Register Parts 3 or 13).

Specialised Mental Health Nursing Care^{2,3}

The provision of specialised nursing care for Alcohol, Drug Addiction, Eating Disorders and the care of women with a Mental Illness related to childbirth. The Person in Charge of the Home be a Registered Nurse (UKCC Register Parts 3 or 13).

Mental Health Nursing Care of those detained under the Mental Health Act 1983^{2,3}

The provision of mental health nursing care. The Person in Charge of the Home must be a Registered Nurse (UKCC Register Parts 3 or 13). 24-hour provision on duty of Registered Nurses (UKCC Register Parts 3 or 13) will be required.

The Registration will specify that the home may receive patients who are liable to be detained under the provisions of the Mental Health Act 1983.

Learning Disabilities Nursing Care^{2,3}

The provision of nursing care for persons with Learning Disabilities. The Person in Charge of the Home must be a Registered Nurse (UKCC Register Parts 5 or 14)

Learning Disabilities Nursing Care for those detained under the Mental Health Act^{2,3}

The provision of nursing care for patients with Learning Disabilities. The Person in Charge of the Home must be a Registered Nurse (UKCC Register Parts 5 or 14). 24-hour provision on duty of Registered Nurses (UKCC Register Parts 5 or 14) will be required.

Acute Psychiatric Hospitals^{2,3}

The provision of mental health care in an independent Acute Psychiatric hospital or clinic, including the provision of day care.

The Person in Charge of the Home must be a Registered 1st Level Nurse on the appropriate part of the UKCC Register for the services being provided.

REFERENCES

¹ May include provision for elderly people with a degree of mental disability, who are able to live harmoniously with people without such a disability, and whose mental health needs and can be appropriately met in that setting.

² Age specific or age range to be stated as agreed between applicant and the registering authority.

³ Age definition is made with reference to the Children Act 1989, and in consideration of the "Allitt" inquiry and the subsequent Clothier report. The requirement to have RSCN staff on duty or available must also be considered.

⁴ The primary qualification given in the categories relates to the Person in Charge of the home. The skill mix of staff beyond this is a matter for consideration by Health Authorities when forming the "Staffing Notice".

25 February 1999]

[Continued

NOTES

The definitions developed are based on patients' nursing care needs and consideration of the medical diagnosis.

The age range is a matter for the registering authority to determine with the applicant for registration having due regard to the physical, social and psychological needs of the planned patient/client group.

The definitions allow for the same definition being used in various settings given the age and other indicators are used to give specific category details.

The distinction between organic and functional disorder is not made, the decision as to the level of, and the degree of disability in those with mental health problems would be an important factor in helping people responsible for carrying out assessments to decide whether a General Nursing Home or a Mental Nursing Home is appropriate.

The need for multidisciplinary assessments is vital if the needs of patients are to be clearly identified and met.

The services of the Community Health and Mental Health Nursing Teams should be engaged as appropriate to provide advice and support in the management of patients' care when the skills within the Nursing Home need to be supplemented. These include Community Nurses and Nurse Specialists, eg Tissue Viability, Continence Promotions, Infection Control and Diabetes Nurses.

The Registered Homes Act 1984 clearly states that a Nursing Home can be in the charge of either a registered medical practitioner or a qualified nurse or in the case of a maternity home, a registered midwife.

May 1998

Examination of Witnesses

MR MARTIN STANIFORTH, Head of Corporate Affairs, MR STEPHEN MITCHELL, Social Care Division, MR MARTIN BROWN, Health Services Directorate, and MR ROBIN HERON, Human Resources Directorate, Department of Health, MISS CLAIRE PERRY, Chief Executive, Bromley Health Authority, NHS Confederation, and MRS JOAN MORTON, Registration Officer, North Yorkshire Health Authority, National Nursing Home Registration and Inspection Advisory Group, were examined.

Chairman

1. Good morning, colleagues. Can I particularly welcome our witnesses to this first session of our new inquiry, and express our appreciation for your written evidence and your willingness to come along to meet us today. I wonder if I could ask you each to, very briefly, introduce yourself to the Committee. Mrs Morton?

(Mrs Morton) Good morning. I am Joan Morton. I am the Registration and Inspection Manager for North Yorkshire Health Authority, and the City of York Joint Unit, but primarily I am here today as the Chair of the National Nursing Home Registration and Inspection Officers Advisory Group.

(Miss Perry) My name is Claire Perry. I am the Chief Executive of Bromley Health Authority, and I am here today in the capacity of giving evidence for the NHS Confederation.

(Mr Staniforth) I am Martin Staniforth, Head of Corporate Affairs at the NHS Executive, giving evidence for the Department of Health.

(Mr Mitchell) I am Stephen Mitchell, Head of the General Social Services Policy Branch at the Department of Health, also giving evidence for the Department of Health.

(Mr Brown) Martin Brown, Head of Mental Health Policy in the Department of Health, giving evidence this morning.

(Mr Heron) Robin Heron, Head of Employment Issues at the NHS Executive, giving evidence for the Department of Health.

2. Can I begin by asking you, briefly, for your thoughts on the current regime, as far as regulation of the independent sector is concerned, positive, negative, your views on the practical experiences that you have got with issues that may well be raised with your particular agencies? Mrs Morton, would you like to start off?

(Mrs Morton) I think, with regard to the independent health care sector, we have been regulating it under the 1984 Act. I think, at times, we have not always regulated it in the manner in which we would have wished to. There are some inadequacies in following through on outcomes rather than inputs. We have looked very clearly at the nursing home side far more because it is the larger sector, but that does not mean to say we do not appreciate there is a real need to continue to monitor adequately and appropriately the independent health care sector.

3. Can you say a bit more about what you mean by outcomes, please?

(Mrs Morton) I would like to see that what the patient receives at the end of the day is appropriate to their expectations and their needs.

4. So, what you are saying is, the current regime does not allow that, or that the way the regime operates does not, for whatever reason, address that? Is it the sort of administration of the 1984 Act's working that needs looking at, or is it the fact that the Act itself is weak and does not address this area, the

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Chairman Cont]

outcomes issue, which, of course, is an area that we have had raised with us very strongly, in evidence, from a range of groups?

(Mrs Morton) I think part of it is the Act, but part of it, as well, is our monitoring process. We have done a lot of work with the NHS Confederation, in the last 18 months, looking at the inspection of the independent health care sector, and provided a lot of guidance to inspectors. But it would be very helpful to have the Act strengthened, or an alternative legislation put in its place.

5. Do you feel, from your perspective as a registration officer, that you are equipped to address the outcomes, presumably, talking here about clinical outcomes, in respect of a number of cases?

(Mrs Morton) Yes.

6. If there are concerns that are raised with you about a clinical outcome in a particular case within your area, how would you deal with that, where it may be to do with the intervention of a particular doctor, how would that be dealt with?

(Mrs Morton) In the first instance, the inspection unit would follow it through and start to look for evidence. Where they felt it was a clinical outcome and they needed the expertise of a medical input then they would go and look for someone who had that expertise; if necessary, buy it in, from either a Trust or another health authority. Wherever possible, we do try to take our expertise from other registration and inspection units, and we share that, particularly in given areas and counties.

7. Thank you. Miss Perry?

(Miss Perry) Yes, a few issues, a range of issues, just to open up. First of all, I think that this whole area begs the question is regulation necessary in this sector, and the Confederation would argue very much that that is the case. I think, if you were to say, no, it is not the case, you would be saying is the open market a sufficient regulatory mechanism on its own, and we think that there are enough examples of poor practice to suggest that, of itself, it is not sufficient. I think, from the evidence I have read, of a number of the private and voluntary providers themselves, they wish to see regulation, in order to make sure that standards are kept high; they have nothing to fear from regulation. I think, also, if you just start at that basic point, there is an expectation from members of the public that when they make the choice about using the private sector they have an expectation that some sort of regulatory framework is there provided for them. I do not think that people who choose, where that choice is available, between the NHS and the private sector are automatically making assumptions that they are providing for their own regulatory framework. I think then, if you accept that regulation is needed, it then becomes an issue, and we have got a number of points about the current legislative framework, about what is covered and what is not. And this Act was provided for in 1984, and since then all sorts of procedures have developed, and an outpatients clinic stand-alone is not covered by the Act but the procedures that they might undertake might be ones that could be considered to be invasive, and with the developments in cosmetic surgery, and others, so that we have moved on since that Act about what should be covered and what is

not. There is also an issue where there are some anomalies about a privately-run hospital that is on an NHS site is not covered, whereas one a mile down the road from that hospital, that is also privately managed and owned, would be covered; so some of those anomalies need to happen. Then there is an issue about who does the regulation, and, clearly, at the moment, there are all sorts of issues about the spectrum of care and how local authorities have some responsibilities and health have others, and so we are looking to reconcile some of those at the moment. And there are ways and examples, up and down the country, about how people can work very closely together and overcome some problems, but, nevertheless, some of the proposals that have been put forward have been welcomed, but there are areas that are not covered by the new CCS proposals, and Martin Brown will talk about some of the mental health ones specifically. But acute hospitals is another area where at the moment it is covered by this Registered Homes Act, and the whole hospital services need to be looked at. There are then issues specifically about the people who practise within these facilities, and, particularly talking of a private, acute hospital sector, there could be a situation where somebody who has action taken against them in the NHS can operate in this sector, and we think that that point needs to be taken on board, though not necessarily through this legislation but through the professional regulatory framework. And then there are issues about enforcement, that are currently within the framework of the legislation, that we think need to be looked at, because the ultimate sanction about being able to close a facility down, people would say that is very ultimate, but actually it is quite a blunt instrument, when you are trying to work towards improving quality for the residents, and, to threaten people with deregistration, the procedures to go down that route are not always the best ways at all to get a relationship between a regulator and a provider to enhance care. And, finally, I would say that, at the moment, the health authorities have a responsibility for both regulating as well as purchasing, and that can lead to conflicts of interest. And, therefore, I think the Confederation would say that they do recognise that those responsibilities do need to be separated.

8. So your organisation's view would be that the 1984 Act is insufficient to deal with the current developments that have taken place in recent years. I would ask you, from your knowledge of the 1984 Act, my recollection was that it was geared very much to concerns within the private care and nursing home sector rather than the private health sector: would you concur with that?

(Miss Perry) Yes.

9. So, clearly, your view would be, and we will get on to this probably later on, that, in looking at reforming the 1984 Act, which is before Parliament currently with the White Paper, we need to look very carefully at the position of the health sector, as distinct from the caring sector?

(Miss Perry) Yes.

10. Mr Staniforth, would you like to respond to the general points that I raised earlier on?

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Chairman Cont]

(*Mr Staniforth*) I think, from our perspective, we would recognise that the world has moved on considerably since the 1984 Act was passed, and that it probably now does not provide an adequate legislative framework for regulation of the independent health care sector. It was largely designed, I think it is fair to say, towards the nursing home end of the spectrum, and there are issues about whether it now satisfactorily does the job for health care, as it has developed during the last 15 years. Ministers have indicated that they would want to consult on the most appropriate way of regulating the independent health care sector, in the light of the proposals in the White Paper, Modernising Social Services, for handling nursing home regulation, and I am sure we shall want to do that shortly. I would echo some of the points that have been made, particularly about the difficulty for health authorities in both commissioning care and being the regulators of care, issues around the potential difficulties of applying common standards and inspection processes when you have 100 health authorities involved, which can cause difficulties, both for providers and for patients. Some of the issues around the need to focus perhaps more on standards and quality of care than always on the inputs to care; and the issues around whether there is a sufficient range of sanctions available to the existing regulatory bodies. So I think there are a number of areas where we would perceive the need for change and on which we would want to consult very widely, and, obviously, also, take account of fully the views of the Committee, in coming to conclusions on how we should move forward into the next century.

11. Could I ask you, in relation to some of the practical areas that we will be examining in this inquiry, clearly, it has been raised with us, and it struck me as rather odd, in a local case I had to deal with, in my area, I do not want to dwell on this particular case, but you may be aware of it, that it seemed rather strange that a doctor can be suspended from the National Health Service, where there are questions of practice issues, where there are doubts about the competence of that doctor, but that doctor can still continue to practise within the private sector. Is this correct, and does this issue concern the Government, if it is correct?

(*Mr Staniforth*) I think, technically, it is correct, and it is an issue of concern. Perhaps I could ask Mr Heron, whose area of responsibility this lies in, if he could lead our response on that, Chairman.

(*Mr Heron*) I think that is right. I think the point to note, in terms of actually preventing an incompetent clinician from practising, apparently by striking off, is a matter for the General Medical Council. What employers, certainly in the NHS, will do, if there are doubts raised regarding a doctor's performance, which suggests that there is a risk to patients' safety, if he was continuing to practise, then, in those circumstances, normally, he, or she, would be suspended until the facts could be investigated.

12. From just the NHS, we are talking about?

(*Mr Heron*) From the NHS point of view, yes. In those circumstances, local employers would actually notify the GMC of that, and, indeed, there is a system of 'alert' letters, whereby it would be reported to the NHS Executive Regional Office, who can authorise a

note to go round other NHS employers, and to the private sector, through health authorities, advising them to contact the NHS body should that person be seeking employment with them.

13. But is it your view that this system perhaps needs to be looked at again, because, certainly, some of the evidence that we have in respect of individual cases, I do not want to dwell on these cases, but some of the written evidence does point to the fact that this system is extremely clumsy and does, in theory, whether in practice or not is debatable, allow for allegedly incompetent doctors to continue to practise in the private sector?

(*Mr Heron*) The system itself, I think, is not perfect. The risk is, I think, that, in actually sort of the spread of these warnings, or these 'alert' letters, there is a question of proportionality, bearing in mind that the doctor in question has not been proved to be incompetent, merely that there have been doubts raised about that which are being investigated. And I think there is a point at which, if that alert was spread far and wide too often then there is a risk of legal redress by that doctor.

14. Can I put to the Department the question slightly the other way round, or another angle on this question. One of the issues that we picked up in written evidence, particularly from patients and patients' groups, is the extent to which, where things do go wrong, within the private sector, where there is incompetence, or mistakes, or whatever, then the usual recourse of the patient is back to the National Health Service. Now it seems to me, from information that we have received, that this must cost the National Health Service a substantial amount of money in repairing mistakes that are made within the private sector. Is this something that the Department has quantified in any way, what is the cost to the NHS of addressing difficulties that clearly do exist within the practice operating in the private sector?

(*Mr Staniforth*) I am not aware that we have sought to quantify that cost, or that it would, in fact, be easy to do so. I will be happy to make investigations, and if there is anything further we can report on that to let the Committee have a note; but, as far as I am aware, we have not sought to quantify that.

15. Miss Perry, is that something that you would like to respond to?

(*Miss Perry*) We would welcome the opportunity to look further into that matter, because I think that there is a concern, amongst Health Service practices, both about the responsibilities they would carry when such circumstances occurred, but also from the point of view of the patients, and the whole issue about what right of redress and recourse and the whole complaints procedures that exist, within the private sector. So I would say that there were those two different issues, both of which need much better looking at than we have had in the past.

16. From your knowledge, for example, of your own health authority, would it be possible, through your relationship with the Trusts in your areas, to establish the numbers of cases where perhaps

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Chairman Cont]

patients have actually come back to the NHS from having been in the private sector for, for want of a better word, repairs?

(Miss Perry) I think, if it is an immediate emergency transfer of an ambulance, where it is a very obvious case, then they are easy to identify. If it is procedures that have been undertaken and there might be some gap before a patient would return or come to the NHS, that would be more difficult to identify. Everything is identifiable; it is not possible to pick it out of our current collection of information, so it would require a further system. But I think if we did investigate it on a small area we could identify whether or not it was worth the administration of having a system like this, because we would find out what sort of scale the issue is. Certainly this is anecdotal within the Health Service, as an issue of great concern that needs to be investigated further.

Mr Gunnell

17. Could I just ask one question, following that up. If a person is insured in the private sector against things going wrong, and that person then has to come into the public sector in order to get that repair carried out, would not the public sector have a claim against that insurance in the private sector so that they can not only calculate the costs of repair but they can recoup it through the private sector's insurance?

(Miss Perry) My understanding at the moment is that that is not the case, even though that might sound a reasonable way forward. I think the analogy that I would give is that, at the moment, if you are insured for your car and you have a car accident which is someone else's fault, the cost of the care is not, in total, going back to the insurance premium; so it is a similar sort of issue there, about whether the Health Service is here to recoup its losses through health insurance, or whether it is here to treat the individual, whatever the circumstances. And, I think, certainly, the other example I have given is one that is subject to debate and a change of regulations at the moment; but I do not think this is one, as we have heard from the Department, that has been looked at, and I think it would be very much welcomed.

18. I would agree that the NHS's job is to treat the patient; but if, in fact, the damage has been caused by the private sector, which is insured against such damage, then I would have thought it was legitimate for the public sector to be able to claim that money back?

(Miss Perry) I think that the issue needs to be looked at, but I think if you go down the path of identifying anybody whose "fault" it is, or might be covered through another policy, then the Health Service starts shifting its ground to potentially going down a route of differentiating their patients, and at the moment we do not do that. But I understand the point you are making, and I think, absolutely, we need to look into it further.

Chairman

19. We do do that on car accidents?

(Miss Perry) We do; we claim a certain amount.

20. So the precedent is there, presumably?

(Miss Perry) Yes, absolutely, but it is not my understanding; although the regulations have changed, and this is not my whole area of expertise, but that there is a certain amount that you charge, there is a charge for the ambulances and there is a charge for a certain amount of care, but only now is it being talked about that the total cost of that episode of care should be charged back. My understanding is that, unless the regulations have changed, and I know it has been mooted.

21. It is obviously going through Parliament at the present time, as you will appreciate?

(Miss Perry) Yes.

Mr Lewis

22. It is to do with this question of recouping costs, I think perhaps to Mr Staniforth, and it is to do with the costs of regulation, which cost the taxpayer, the Department of Health, and particularly if we are to enhance regulation it would cost significantly more perhaps than it costs at the moment. Now, as I understand it, the amount that is recovered currently is about 50 per cent of the total cost, perhaps less than that; if regulation were to be enhanced it would be perhaps even a smaller proportion, and I am just wondering how the Department feels about the public purse bearing significant costs for regulating the private health care sector?

(Mr Staniforth) I think the issue of fees to be charged under any new regulatory arrangements that we might want to introduce is one thing we would want to consult on and take views on. Certainly, there is an issue about the ability to recover the full cost of inspection and regulation from those who are being inspected and regulated, and I am sure that is something on which we would want to seek views more generally, as part of our consultation process.

23. So, in principle, there is a belief that a significant proportion, if not all, of that money should be recouped?

(Mr Staniforth) I certainly think there is no assumption against that, it is certainly not an option we would rule out. I know that on the social services side there is already work in hand: Stephen.

(Mr Mitchell) Yes, the commitment in the Social Services White Paper to the creation of the Commissions for Care Standards, which will include the regulation of nursing homes, is that, as far as possible, the full costs of regulation should be recovered from those organisations providing services and being regulated, in all sectors; so local authorities will have to pay for the regulation of services at full cost as well as the private sector. Now the financial regime for the Commissions for Care Standards that will be established will allow for Government funding of their work, but the operating assumption will be that the full costs of regulation are recovered. It is certainly true that, under the current regime for regulating social services and nursing homes, including the independent sector, health authorities and local authorities do not recover their

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Mr Lewis Cont]

full costs. We have actually got some research going on, that we funded, at the Personal Social Services Research Unit, in Kent, to actually chart the variation in the amount of cost recovered and look at some of the variables influencing the cost structures and the recovery rates, and so on; we want to use that research as the basis for providing advice to Ministers about how should they look at the charges for regulation under the current regime, and how does this need to inform the drawing up of financial regimes for the new system.

Chairman

24. The taxpayer is, effectively, subsidising the private sector?

(Mr Mitchell) It is subsidising the regulation of the private sector, yes.

25. Can I just come back to John Gunnell's point, which I think was very important. The analogy with the car accident. I cannot see any difference between, if I am insured for driving my car, which I have to be, by law, and I have a smash, and I have to make a contribution through that insurance to the costs of transporting me to hospital, or care, or whatever, as is the case, as is Government policy, what is the difference between me being in BUPA and being insured for a treatment that goes wrong and then having to go to the NHS for treatment? I cannot see any difference. What is the distinction?

(Mr Staniforth) I think there are issues about how you necessarily link up the subsequent treatment that you may require to what may or may not have gone wrong in the private sector; and there are also issues, I think, about ensuring that any systems we have do not unnecessarily increase bureaucracy and the costs of management in the NHS, in a way that might outweigh the gains to the NHS from going down that sort of a route.

26. The picture we gain from some of the witnesses, from some of the evidence that we have got, is that the NHS is paying out a fairly substantial amount of money to deal with repairing problems that have gone wrong in the private sector. I, as a taxpayer, frankly, resent having to subsidise the private sector in this way, I do not think I particularly wish to do that, I would imagine most people, who believe they are paying for an NHS, would feel the same as myself?

(Mr Staniforth) It is certainly not a policy that we have pursued in the past, and, clearly, would be one that Ministers would need to consider very carefully, if they wanted to go down that particular route. I do not think I can really add anything to that, at this stage.

Dr Stoaite

27. Just a very quick supplementary on that, really. I want to ask our witnesses do they consider it is right that the system at the moment, where the public sector, effectively, subsidises the regulation and registration of the private sector, is correct or not, is it something that our witnesses think is the right thing to do? Perhaps Claire will want to answer.

(Miss Perry) I do not think it is right that there should be a subsidy. I think that there are problems about how you go about recouping and how you identify blame, and we do not want to get ourselves into having such an adversarial relationship and a bureaucratic one that it outweighs any of the benefits. And at the moment I only know anecdotally that there is a feeling within the Health Service that this should be stopped, but I do not know the scale of it, so until we have worked out what the scale of it is, then we need to take action accordingly, and I think that otherwise we are speaking anecdotally. And I think it would be very much welcomed by the Health Service to be absolutely clear about what the scale of this is, and then work out whether or not, therefore, it is sufficiently important to take action to stop it happening.

28. Perhaps I can ask Mrs Morton, because we are not talking anecdotally about the cost at the moment of registration?

(Miss Perry) Not of registration, I am sorry.

29. Because we have got figures that say that, figures we have been given are that, the cost to the NHS is approximately £15 million a year, over and above what they recoup. Is that something that ought to continue?

(Miss Perry) Just to finish, yes, there are two sides to this. There is one which is about the transfer from the private sector into the acute hospital setting, or any other setting, into the Health Service afterwards. But there is then also an issue about the cost of the regulatory system; and, quite clearly, that should be covered in the overhead costs of running the private sector that should be recouped in their fee structure.

30. Do you agree with that, Mrs Morton?

(Mrs Morton) I do. I believe that at the moment it will vary from authority to authority, according to the size of the teams and the area they cover, and the costs, of course, if you are in a large geographical area, can be larger than if you are in a small, tight-knit community. At the present time, taking my own authority, our income is about £90,000 a year short on what we require for continuous registration and regulation. I do not believe it is appropriate that health money that could be used for patient care should be being used to regulate any one sector.

Mr Lewis

31. Just on the same point, very quickly, I think, again, perhaps to Mr Staniforth, or the appropriate Department representative. The Government has given indications in this area about general policy, has it not, which is that if people choose to use the private sector that is all well and good, that is entirely a matter for them, but the issue is that the state should not be subsidising that, and they have indicated that, in terms of the private health care tax breaks that have been got rid of, the assisted places scheme, in the context of education, where, as I say, people make choices, fine, but it is not the public purse's job to subsidise those choices in terms of the private sector. Do you not think this is an area where, if you like, Government policy is leading us down a

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Mr Lewis Cont]

particular road, in saying there should be a neutral cost effect, in terms of regulation of the private sector?

(Mr Staniforth) Certainly, in terms of regulating the independent health care sector, I think the precedent, in terms of what has been said in the Social Services White Paper, a full cost recovery, is probably one that may well apply across to the health sector as well. What I do not want to do is pre-empt what Ministers might want to say in a consultation document that they have not yet issued, or the outcome of that. But I think we have been clear of the line on social care regulation, and it may well be that that would be an appropriate model for the health care sector.

Mr Gunnell

32. If we could come back just for a while to the review that is promised in the Social Services White Paper, because we have had two goes at it. First of all, we have heard Mr Staniforth say it applies primarily to the nursing home sector, and what, I wonder, is the timing of this review, are we likely to get a new regulatory system in this Parliament, in the current Parliament, is it going to extend there, and what is its scope? Is its scope in any way going to be altered by the changes in the role of social services, because we recognise and in many ways we strongly support the greater degree of cohesion between health and social services work, so that the social services department, although primarily dealing with social care work, is not, in a sense, so strictly confined to that as it has been? So what is the scope of the regulations going to be, and are they going to be in place during the lifetime of this Parliament?

(Mr Mitchell) Can I answer what the Government's policy is, as set out in the Social Services White Paper. The regulatory sections of that White Paper were based on, in large part, the review by Tom Burgner, which was published in November 1996, and that recommended that Government should establish a new, independent regulatory system, encompassing social services and actually increasing the scope of the social services, brought within regulation, but also nursing homes, in the sense of care homes. The Government's policy on that is clearly indicated in the White Paper, it requires primary legislation to establish eight Commissions for Care Standards on a regional basis, which will regulate and register, inspect, all social services within the scope of the regulation and nursing homes, in the sense of care homes. The timetable for that is dependent on parliamentary time; as you know, there is not a Bill in this parliamentary session, it remains to be seen whether time can be found for it in the next parliamentary session. If there is a Bill in the third session of Parliament, i.e. a Bill on social services regulation, in the Queen's Speech, in November this year, our judgement is that it ought to be possible to achieve implementation of this new regulatory regime just within the lifetime of this Parliament, probably from, say, 1 April 2002. The scope is as set out in the Social Services White Paper. What is indicated in the White Paper also is that, while the current regulatory regime, under the Registered Homes Act, encompasses the

independent, acute hospital provision, the Government has not decided, as yet, what to do about the regulation of those services.

33. Are the regulatory agencies, is it going to be the Social Services Inspectorate, as we have it now, or is their role going to be changed?

(Mr Mitchell) The Social Services Inspectorate's role will remain as the Inspectorate of Government. Government is not a licenser of services. And, in fact, one of the roles of the Social Services Inspectorate will be to keep under review and inspect the activities of the Commissions for Care Standards. The Commissions for Care Standards will be fundamentally licensing bodies, they will be inspecting against nationally required standards for care homes, nursing homes, domiciliary services, and so on, and deciding whether the standards of input, process and, to some extent, output are good enough to warrant them being licensed. We envisage that they will have their own workforces of inspectors, in the same way that local authority registration and inspection units and health authority registration and inspection units have their own workforces of inspectors.

34. The way they function now, you would expect them then to function in a broadly similar way?

(Mr Mitchell) Yes. There are clearly improvements that have been identified as necessary, in the training and equipping, and so on, of the regulatory workforce, if you like, and we will be looking to encourage and take initiatives in that, as part of implementing this new regulatory regime.

35. Will there be an intention to impose the same standards on both the public sector and the private sector?

(Mr Mitchell) Indeed, yes. There is a clear commitment in the White Paper to consistent, national standards for all regulated services. As a first step, the Department of Health and the Welsh Office commissioned from the Centre for Policy on Ageing, last year, some exemplification work on what nationally required standards for residential homes and nursing homes for elderly people might look like, what they would encompass, how they would be framed, what evidence would be needed against them, and that sort of thing. The Centre for Policy on Ageing produced the results of that commission to our Minister last month, and the Department of Health will shortly be consulting on those standards to see if they are the kinds of standards that people think should be applied under the new regulatory regime.

Mr Lewis

36. I think, Miss Perry and Mrs Morton on this issue. It is about the balance, I suppose, of effort and priority that is given to regulating nursing homes, in relation to the acute sector, and whether, in fact, there is an imbalance, and that the concentration, inevitably, is on nursing home regulation and inspection rather than on the private, acute health sector. And, also, linked to that, whether you feel that inspection teams have the necessary expertise to make judgements about clinical outcomes in the acute sector?

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Mr Lewis Cont]

(Miss Perry) Perhaps I can start, because the situation there is very much up and down the country. Obviously, the number of, if by acute sector you mean acute hospital sector and not nursing homes who have acute, short-term episodes, we are talking acute hospitals here, I think that there is a balance. In an inner London health authority, the registration and inspection team, with four or five acute hospitals within them, are going to have a much bigger role than in a health authority that does not happen to have any, or very few, or one, or whatever, or all of their acute hospitals happen to be on NHS sites, and therefore the regulation, the legislation does not occur. So I think it is varied. To those, Joan will be able to talk about, where there are hospitals, what the balance of time is spent on both, and, certainly, speaking within our own health authority, rather than from the Confederation, that also depends on just not the numbers but what issues are going on. And so if you have a complaint and a serious incident that occurs then, naturally, your effort and the time investigating it is going to be geared into managing that particular incident, for as long as that goes on. As to where the expertise occurs, it is incumbent upon the health authority, obviously, through the legislation, to ensure that it has got the necessary expertise, and that comes back to the fee level, there is a tension if the fees are not automatically passed on, that the health authority will have to be providing a higher level of expertise than the income generated from each facility.

(Mrs Morton) I think that in the past we have not always been as vigilant as we may be, about the acute sector; and, yes, because there have been far more nursing homes they have hit the media far more often, then they have taken some priority. As time has gone by and we have started to amalgamate and have four or five health authorities coming together, we then cover far larger numbers of the acute sector; that has then meant that we have had to increase our expertise and skills and competencies within each of the individual inspection teams, and that we have done by going out and training our staff and doing our recruitment in such a way to ensure that we can cover all aspects of care. If we look particularly not just at the acute medical/surgical, but look at some of the psychiatric care and mental health care, particularly forensic psychiatric units, as inspections units, we have had to look long and hard at the skills and competencies of individual members of staff to regulate, and also to recognise some of the issues that are forthcoming from some of these places. We have also managed, by getting together and working far more on a national scene, through the NHS Confederation and the National Advisory Group, to pull together a database of all those skills and competencies up and down country, and when an issue arises where we have got concerns we can go to one of the other authorities and ask them for their expertise, to support the work that we are doing. I think a lot does depend on the geographical area and how many places are actually being monitored within that area.

37. In terms of inspection teams, and the skill mix within those teams, are there occasions when specialist professionals will be co-opted to assist with inspections, where you did not feel the existing team

did have the necessary and appropriate skills to deal with a hospital setting, for example, to make judgements about a hospital setting? Does that happen?

(Mrs Morton) Yes, it does happen, and I think it happened more so in the past. We did a lot of contracting with Trusts, as we came out of this division into Trusts and health authorities, so yes, there are contracts with the Trusts, with people like physicists, to deal with lasers. I think it will vary, again, from each authority as to the size of the team; if it is a small, one or two inspector team, they will not have all those competencies, and therefore they may well be contracting outside.

38. Just one other point, in terms of alarm bells ringing, because, in reality, if you look at the limited resources, often inspections are carried out kind of perhaps a couple of times a year, unless there is some sort of crisis or concern about an establishment. In terms of flagging up concerns about, say, an acute setting in the private sector, is there any auditing process; it has been referred to, people coming back into the NHS because there have been difficulties as a result of treatment in the private sector? Is there any mechanism within health authorities, for example, for evaluating when that is happening too frequently, or should there be?

(Miss Perry) I think this goes back to the same point that we had before. And whilst I think the principle is accepted that we should not have cross-subsidisation and we need to try to understand that, there are difficulties in implementation, because, for example, in an elderly care nursing home, when somebody deteriorates to the point at which it is not the fault or the responsibility, it is not through care, but there comes a point when that nursing home is providing nursing care and the patient needs a higher level of medical care than can be provided, and they have to transfer. There are similar issues in the acute sector, where, through no fault, patients will need to be transferred. And I think the point of disaggregating is going to be a tricky issue when we go down this; nevertheless, the principle about there should not be NHS subsidisation, I think, is generally accepted. As to whether we gather information at the moment, I already mentioned that we do not, to my knowledge, gather information routinely, as part of the data that we collect at the moment that identifies whether or not the patient has come immediately or within the whatever you might call recent past from a private establishment, and whether or not there is a linkage between their current condition and that which was managed in the private sector. And all of those complications will need to be unpicked, if we are going to go down that path; which is why we would recommend doing it on a small scale to find out how feasible it is.

Dr Stoaie

39. I want to come back to something that Mrs Morton touched on earlier, which is about the balance, whether we are getting the balance right between the nursing home sector and the acute private hospital sector. To pick up a point that we

25 February 1999]

MR MARTIN STANFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Dr Stoate Cont]

have been told by written evidence, why is it that in over 300 tribunal cases not one has related to private hospitals?

(Mrs Morton) I think there may be two reasons for that. One is that the private hospitals are very susceptible, like we all are, if we run a business, to media implications, and, in fairness to the private hospital, if things are drawn to their attention then they usually action them. Those that do not action them are ones that often close down very quickly, and I am thinking of probably the smaller clinics and some of the small abortion clinics, they close down very quickly and go out of business.

40. So you are saying then that they have either cut and run or they have cleaned up their act?

(Mrs Morton) That is generally what are the perceived actions.

Chairman

41. Can I ask you a question to clarify my understanding of this point about 300 tribunal cases. From your knowledge of the tribunal system, certainly my understanding is that many of the tribunal cases are taken not by your officers but actually by appeals by providers, against judgements of officers, it might be room sizes, or whatever, do you have any breakdown of, say, within this 300, what percentage might actually be taken by your officers, or your colleagues in other authorities, and by the appellants themselves, the providers, appealing against your rulings?

(Mrs Morton) They are all appeals against the rulings of the authorities, whichever they are, they are all appeals.

42. So the appellant is the person who is the provider?

(Mrs Morton) Yes.

43. They go to the tribunal?

(Mrs Morton) Yes.

44. It is a very important point, that. It is not you taking them there?

(Mrs Morton) No. They are actually appealing against the health authority or a local authority decision.

Dr Stoate

45. If I could pick up on something beyond that. That leaves me feeling quite uneasy, this idea that you say that they close down very quickly, because, in several sectors in society, we know that when things close down very quickly they open up very quickly again, the following day, under new management, they change their headed notepaper and they are back in business. Now we know that happens in all sorts of sectors in society, there are many television programmes which allude to this. Are you sure that is not just happening in the private acute health sector?

(Mrs Morton) No, I am not sure. I wish I were. I think there is an issue about the change of company names, and some of the lease problems of properties, perhaps more so in the nursing home sector and the

residential care home sector than in the acute sector. But, yes, I cannot say that I am sure it is not happening.

46. And what do you think we should do, to try to improve the situation, because I am quite uneasy about it?

(Mrs Morton) I feel that we need to be looking strongly at the legislation, to ensure that the persons registered are the persons that end up that will have the responsibility; at the moment, we are almost registering premises, with a person nominated within that. I think it is very important that, in the long run, we make sure that, anybody who does not comply and is taken for deregistration, the action is followed through; at the moment, due to the costs to health authorities and local authorities, if a home closes down, it is often deemed to be inappropriate to start to take them right through the appeals process, because of the cost implications of that.

47. So, effectively, they are getting off scot-free, because it is cheaper to forget about the situation when they have closed down than it is to follow through the procedure, to ensure they have not opened up again under new ownership?

(Mrs Morton) There is a safeguard, but it depends on honesty, and it depends on the new authority looking at all avenues. When somebody reregisters, there is a requirement for them to inform an authority anywhere else where they have been previously registered. At this present time, they would then write to that authority and ask for evidence that they were fit people at the time that they were registered.

Chairman

48. Can I just raise a point. I wanted to press you on the issue of the fit person concept, in the Registered Homes Act. My understanding of the way it applies to the nursing home or the care home is, we identify a fit person, who will be a qualified and suitable individual, who is responsible for that home. Am I correct in that assumption?

(Mrs Morton) We would look for two fit persons; there is a fit person to be registered and a fit person in charge.

49. Right; so there are two fit persons, where we are talking about the care homes and nursing homes. How does this work, in respect of the private health side, the private medical side; who would be a fit person, or fit persons, that you would register?

(Mrs Morton) You register the company and you would follow up on directors for the fit person.

50. So a national company providing care could have one or two fit persons based in London who were not actually working in the clinic in Yorkshire, or your area, or wherever?

(Mrs Morton) That is for the person registered, not for the person in charge. The person in charge is either a doctor, or the nurse, for a nursing home, who has the clinical management of that particular premise.

51. Yes, but if we go back to the point that I raised with Mr Staniforth, about the issue of doctors in the NHS being suspended and still being able to practise

25 February 1999]

MR MARTIN STANFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Chairman Cont]

in the private sector, what knowledge would you have, through your registration arrangements, of who was being employed within a particular clinic or hospital in your area?

(Miss Perry) Not for the medical staff; you do have a list of all of the nurses with their ...

(Mrs Morton) We have a list of the consultants.

52. So you have no record at all, you would not have a record of that?

(Miss Perry) You do have, of the consultants, sorry.

53. Of the named person, the fit person, you have got that?

(Mrs Morton) Yes; we would also know who was working.

54. But there may be others, many others, who were working there as well, that you would not be aware of?

(Mrs Morton) We would.

(Miss Perry) Yes. I think the issue is, if somebody is, for example, accepted as being a competent person when a facility opens and is also working in the Health Service, and then something happens in their Health Service that calls into question their abilities and they are suspended, it does not automatically pass on, except for the procedure that we have talked about, about passing these alerts around, that the private sector will either get to know, although the system is that you do pass these alerts round, when we get them, but you do not have any rights over who operates in those circumstances, you cannot take any action on who operates within a home.

(Mrs Morton) What we do have, when we do inspections, we check who is employed in the home, and we look for adequate staffing; under Regulation 12(1)(a), there is a requirement for adequate technical and ancillary staffing, and we would look at all staff within those areas.

55. What do you mean by "employed"?

(Mrs Morton) Anyone who is practising within that.

56. So not just somebody who may just come in on a sessional basis?

(Mrs Morton) We would know who was doing the sessional basis and we could check those names against "alert" letters. If we look at something more like the mental health units then, generally, the doctors and consultants there are employed, so therefore we would follow them up.

Mr Gunnell

57. So you could not have a situation in which you had got a company that is managed remotely, so it is managed by a company in London and its fit person actually becomes a person who would not be acceptable, because they had been suspended from the NHS, so that person in Yorkshire could be a person whom you have serious doubts about but the company is managed in London; that situation could not happen?

(Mrs Morton) I think there may be some confusion about who is managing. If we are talking about the company, and the directors are usually the people who are registered, if we are looking at who is

actually practising in the hospital, who is actually working in the hospital, it would be the person in charge and any staff that are employed within that hospital.

Julia Drown

58. Just on this issue, you were explaining, Mrs Morton, the process that takes place if somebody who was registered as a fit person and was being investigated by one authority then tries to reregister in another authority. As I understand it most health authorities investigating an establishments drop the relevant case when an establishment closes down. You say there is the voluntary process that takes place. It firstly relies on the individual admitting "Well, I did have this clinic, this hospital, somewhere else, in another health authority, which I closed down four months ago". Then the health authority considering the application will write to the previous health authority and say "Are these people fit to practise?". But if the previous authority had not pursued the case to the end and had not deregistered them because they had closed down, presumably, all you could say is "Well we have some anxieties but we haven't been able to prove the person is not fit to practise"?

(Mrs Morton) I think we would be prepared to put forward that we had evidence and what our evidence was, to allow that authority to make a clear judgement.

59. So then they would be able to refuse to register it?

(Mrs Morton) Yes.

Dr Stoate

60. Just to pick up a further point on that. I have got here an article from the *Sunday Times*, dated 14 February. You are talking about these "alert" letters, which go round, which I accept, and I understand about "alert" letters. But what about, for example, the case where somebody has had his licence revoked in Canada and then comes over here and has worked for private fertility clinics, done some work in a private hospital in London; now, surely, that would not be covered by your "fit person" at all, because they had not even registered in this country, initially, they have actually had their licence revoked in Canada?

(Mrs Morton) I am not absolutely clear, but I would have expected them still to be registered with the General Medical Council in this country, just as a nurse is with the UKCC, once they come into this country.

61. And yet somebody with significant worries in a different country had managed to work quite openly in private units in this country, without, apparently, any let or hindrance?

(Mrs Morton) I would have expected that to be the province of the General Medical Council, for them to action and make sure they have got appropriate systems to vet people.

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Dr Stoate Cont]

62. The point I wanted to come on to was really about clinical issues, and I wonder if you could elaborate a bit more on to what extent the inspection activity really does address clinical issues?

(Mrs Morton) I think the Act only sets the entry for registration, but there are a lot of areas about what we expect a hospital to provide, what it is they are proposing to provide, how they do that and how they have got quality assurance with that, and what are those outcomes, and I think we then can start to inspect against those issues. Particular areas that we can do is to ensure that treatment is only provided where the place, the staff and the equipment are adequate for their use. A large company and hospital, a few years ago, did not have, for example, an active gas/air exchange system in the theatres; the Inspectorate were able to pick that up, discuss it with them, come to an agreement, through working with the Health and Safety Executive, to have that put in. We advise on the layout and good control of infection, and we would look at infection control, give advice on planning. If you think about a recent situation where a hospital was taking dirty equipment through a clean area, and it was looking at a circulatory system. So we look at the adequacy of the staff, we look to ensure that they have got adequate training and expertise, that they have got policies and procedures in place to cover all aspects of care; for example, something like the disposal of body parts, or the use of body parts, or anything else, for the purpose of research, and it would need to be within agreed standards, not only with the regulations but with other people, such as the General Medical Council, and Users' Rights.

63. Just two further points, Chairman, if that is alright. You have talked about outcome measures, but how do you use outcome measures on emerging or controversial medical techniques, which actually may not have many measurement outcomes, it may never have been evaluated; how do you approach that type of perhaps alternative medical practice, which might go on in a private clinic?

(Mrs Morton) If I take, for example, something like detoxification, because that is a changing pattern on quite a number of areas, if that one came towards us we would ask for a clear insight into what the procedures were, what it was they were looking at, and this would be one of the occasions when we would have to go and ask for other expertise to look to see if they felt it was safe practice. We would expect the doctors that were working there also to be able to give a good rationale on the safety procedures that they were putting in place to ensure clients' safety.

64. You are therefore talking more about safety and outcomes, because if the only outcome is patient safety then that does not give the patient much protection as to whether the treatment being offered is of any value?

(Mrs Morton) I would be expecting some of the people that I went to for advice, I would not have enough information, nor would my team, to know that in depth, we would go to other clinicians for that advice.

65. But I am still not satisfied about the outcome measures, because, yes, you can look at patient safety, yes, you can look at procedures in theatre, but

that still does not give me any reassurance that some of the emerging techniques used by some of these clinics may, in fact, be either useless or pretty much so?

(Mrs Morton) They may be.

66. One last point, Chairman, before I finish. Is it not a fact that a doctor can work at a clinic and that most health authorities would not check on that person's competence?

(Mrs Morton) I do not believe that, but I could not state for a fact that it is not true.

(Miss Perry) I just wanted to add a relevant point, which I think is a relevant point, and the Confederation do, on this issue, which is, all of those questions are pertinent to an acute hospital setting, where registration and inspection does take place. There is all sorts that might be happening in what you are talking about in an outpatient clinic, where registration and inspection does not have any coverage anyway.

Dr Stoate: A good point.

Julia Drown

67. My point goes back to Dr Stoate's previous point. If you found that there was a detoxification procedure going on that you thought was not an appropriate one, am I right in thinking you would not actually have the powers to say "Stop that", you could try to persuade the clinic, but the only thing you could do would be to move to deregister it? And the Department of Health might want to comment on this, because in their submission I noticed they said that the primary concern of registering authorities is to ensure that patients are properly cared for, according to their needs. Most people would imply from that that the procedures being undertaken had been subject to some issuing, but actually the powers, in terms of doing anything about it, if you did think a procedure was inappropriate or positively unhealthy, are limited. Am I right in that?

(Mrs Morton) There is some limitation. We would have to go down the "fit person" thing, as to providing what we believed to be inadequate care, and we would have to prove it; that could take time.

68. So you would have to do that, even if everything else in that hospital was alright, as far as you were concerned?

(Mrs Morton) If that was the line we took.

(Mr Staniforth) I would merely say that I think we would recognise that there is a gap, in that deregistration is, in effect, the main, if not the only, sanction that registering bodies have, at present. I am sure one of the issues that the Minister will want to take views on, when we consult, will be whether that is right or whether we should look for a wider range of powers for whatever body may end up regulating the independent health care sector; but, obviously, I do not know where we might end up on that.

Mr Gunnell

69. That brings us, I think, logically, to the two bodies that the Government have set up, which do not appear to have any jurisdiction over the private sector. That is the National Institute for Clinical

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Mr Gunnell Cont]

Excellence, and we met the Chairman-Designate a week or so ago, and he told us that he did not have any remit towards the private sector. And it also applies to the Commission for Health Improvement, which also is a public sector body and does not have any regulation in the private sector. And I wonder whether those are logical positions. When we met the Chairman-Designate of NICE, he described to us the work that they would do, and it is quite clear that they will come to a position that certain treatments are important and essential for some categories of patient, and the same treatments may not be particularly valuable for other categories of patient, and he will be able to recommend that, and, therefore, for example, give to the Department a clear guideline as to which patients should get particular treatment for MS, for example. Now when he comes to the fact that he has no remit at all in the private sector, that must mean that, for instance, the private sector can, in one sense, offer what treatments it likes, and it can also make claims about those treatments and about their effectiveness, in order to sell its services, and the National Institute may know that those claims are exaggerated and it is not strictly honest advertising. Now it seems to me that NICE ought to have some remit in the private sector, because their advice is advice on health matters and on excellent treatment in health, and it seems to me that the private sector is not bound to take notice of them, but it would seem to me they also ought not to claim that they can offer treatments which clearly are not likely to work. So I wonder how you see the two interacting, and whether you see either a role in terms of advice being picked up by the private sector, or a role in which the claims of the private sector can sometimes be tested against what NICE has to say?

(Mr Staniforth) If I can pick up on NICE's role. Clearly, it is there to assess new and existing interventions for clinical and cost effectiveness and disseminate that information to doctors, nurses, other frontline staff; and, as far as I can see, I would anticipate that that guidance would be available to and relevant to professional staff working in the independent health care sector as much as to those in the NHS, so that they would have access to the information on clinical and cost effectiveness. On the second point, of perhaps people choosing to hype the benefits of treatments which perhaps NICE has indicated might not be clinically and cost effective, many patients, obviously, who are treated in the independent sector will be insured patients, through private medical insurance, and I am confident that the medical insurance companies would be interested in testing the validity of claims about particular outcomes in their consideration, and looking at the guidance which NICE will produce in relation to the contracts which they place with independent sector hospitals. And, clearly, we would be interested in ensuring that where there is an NHS patient in an independent sector hospital, for whatever reason, the NICE guidelines are being looked at properly by that provider.

70. I can see that, in one sense, however well NICE advise people that certain treatments for the condition as they have it are not going to be worthwhile; they can quite easily choose to pay for them anyway, in the hope that they would be. So I

understand that, if you have a patient who is under private health care, they have the right to choose to spend their money on something which NICE suggests will be ineffective. But it would seem to me it brings us back to the question we covered earlier, that if they go into the private health care field and undertake something which is not recommended by NICE, or is definitely contrarily recommended by NICE, if things go wrong then, as a result, and they come back into the NHS, we have got an additional reason, it would seem to me, for the NHS not having to pick up the bill for them being lured by advertising which is not strictly honest?

(Mr Staniforth) I take that point, and though, obviously, in some of these cases, these might be people who were choosing to pay themselves rather than to be insured, because, as I say, I think the private medical insurance companies will have an interest in the findings of NICE in the work that they do with independent providers, I think there will be some real issues about somebody who was paying as they went, as it were, for private treatment and took private treatment that was inappropriate and came back to the NHS, where you have no insurance company, or anyone else, to go to.

71. Thank you, but it does seem to me to be an area where at least there will be cases that will arise in the future?

(Mr Staniforth) I suspect you may be right.

Chairman

72. Can we move on to the issue of the separation of regulation and looking at the split between nursing homes and acute services and talk about the implications of this. What are your views on the separate regulation of private nursing homes and the independent acute sector; probably Mrs Morton and Miss Perry will want to respond to that one?

(Miss Perry) First of all, there is already recognition within the public services of the split between those registering residential homes and those registering nursing homes, and the new legislation proposes, in our view, quite rightly, to bring those together. Where there is a gap is, because it was not covered by the initiating inquiries and investigations, that then we all end up with the Commission for Care Improvement having that unification of responsibility, but the private hospital sitting outside that, and there is a question in our mind still about where is that responsibility going to sit, and that certainly needs to be resolved, I think there is a recognition of that. So there is one issue there about where the expertise sits. There does not seem to us, as the Confederation, to be any reason why the new Commissions could not also take on a responsibility for the registration and regulating quality within the private acute sector, if the remit for those Commissions were changed to accommodate that. As to questions about where they would get their expertise from, as Mrs Morton has already said, that expertise exists and could be transferred, and if those Commissions were responsible and did not have all of the expertise they could purchase that in on a contracted basis.

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Chairman Cont]

(Mrs Morton) There is also an issue, of course, that we have looked at residential care and nursing home care, and there is the dual registered home which covers both, and we have always said it was an anomaly, where they were registered and inspected by two different authorities. This may happen in the future, because some of the acute sector do have long-stay beds as well that could be caring for the elderly and people who come within the new legislation, for Modernising Social Services documents. I think, the skills and expertise, once we start to move some of the health authority staff out into these new Commissions for Care Standards, that expertise will go with them; there will not be a lot of nurses left in health authorities who have the ongoing clinical expertise, as the registration and inspection units do have at the present time.

Mr Gunnell

73. If you are going to separate the acute and the non-acute care for the purpose of regulation, you obviously do have a lot of multi-purpose premises, such as, for example, the mental illness services, which will be the sort of case you had in mind, I think, and how would you cover them, under those circumstances?

(Mr Staniforth) Could I come in briefly, just to say that I think Ministers have not yet made a decision, and will not until the outcome of consultation and this Committee's thinking is available, on whether to split off the regulation of the independent health care sector from the regulation of nursing homes, or not. There is clearly an issue to be debated as to whether the Commissions for Care Standards should take this work additional to their work on residential and nursing homes, or whether there should be a separate, different regulatory arrangement. So, clearly, if the Commissions for Care Standards were to cover the whole waterfront then the issue of multi-purpose providers would be easily resolved. I think the issue would obviously become more tricky where the Government decided to have separate regulatory arrangements, and, I think, there, we would clearly want to make sure, if that were to be the outcome, that there was proper discussion and agreement between the regulatory bodies, the Commissions for Care Standards and any separate body for health care as to how these dual-purpose premises should be regulated in order to avoid, or minimise, the scope for dual inspection, dual regulation and potentially different standards being applied.

74. In a way, you can say what are the sort of inspection skills required; are they the same inspection skills needed for each section, and, in a sense, if you are doing an economic audit at the same time would the skills be the same in each case? Because, if the skills for inspection are the same in each case then it seems to me the issue of separating them is not necessary?

(Miss Perry) The skills exist at the moment to do the regulation around private and voluntary nursing homes and acute hospitals sitting within health authorities, and the Confederation does not see any reason why those skills cannot transfer into a new body, in order to preserve those skills and in order not to then have a separation, as we have now,

between nursing and residential homes, and we will amend that one by having the new Commissions but create a separate one between acute hospitals and nursing and residential facilities. So the view of the Confederation is, let us preserve them, let us keep the skills together, they are there at the moment, let us not have the separation. So that will be the view of the Confederation into the consultation that needs doing.

75. That would seem wise, would it not, in these circumstances?

(Miss Perry) Yes.

Chairman

76. If we can turn to the Modernising Social Services document, and can I, in a sense, pick up, Mr Staniforth, the point you made a moment or two ago, and put to you what has been put to me, that there is a feeling among some people that this document has, effectively, sidelined the regulation of the private health care sector, for reasons, some would suggest, to do with the Government's attitude to the private sector; that is a political question, to some extent. But what you were saying a moment or two ago, that this is still very much on the table, it is still very much under consideration, as to whether it will be part of the new Commissions, or whether it might be a separate organisation, am I correct in that assumption, from what you said?

(Mr Staniforth) That is absolutely right. That is one of the issues, I am sure, that when we consult widely Ministers will want to seek views on, exactly what structure is most appropriate for regulating the independent health care sector, given the decisions that have been made and announced in relation to nursing homes. I think, in fact, while it might seem perverse, it is actually logical to have sorted out the proposals for the nursing and residential home sector first and then to say "We have another sector here which is different and we need to think separately, in the light of those decisions, about how best we should regulate that." And that is the stage which the Government has now reached, and will be wanting to consult very widely on proposals for a new regulatory structure.

77. Would you subscribe to my previous interpretation, that when the 1984 Act was drafted the private health sector was kind of tagged on, as "We need to look at this as well, and pop it in this dustbin", which really was perhaps, at the time, rather inappropriate? And is there a danger that we might do the same here, with Modernising Social Services, that we are not really thinking very clearly about the very marked differences that do exist between the sectors, care and health, so to speak?

(Mr Staniforth) I was not involved in this area in 1984, so—

78. I was not saying you were, I just wondered what your impression was?

(Mr Staniforth) I think it is fair, probably, to say that the private health sector then, the independent health care sector then, was rather different from what it is now, in terms of the range of treatments and types of care that it provided, but I think it is clear that over the years it has become growingly

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Chairman Cont]

anomalous for large acute hospitals to be registered and regulated as if they were nursing homes. I think also we need to recognise that the independent health care sector is actually itself quite a varied sector, from large hospitals, through clinics, to palliative care, hospices run largely by charitable and voluntary organisations, and I think, therefore, the time is right now to look at how we best regulate that and recognise that the current provisions do need updating. I think we do need to be careful that, wherever we end up on the regulatory spectrum, the regulation is properly tuned to the independent health care sector and that it is not seen as being, as you put it, tagged on to the much larger body of social care. Now you could do that under Commissions for Care Standards, it would be perfectly possible to organise it to do that, you could do it with a different body to regulate the independent health care sector, and, clearly, we shall want views from all those affected in helping Ministers come to their conclusions.

Julia Drown

79. I just want to pursue a bit further who should be included under the new Commissions for Care Standards. We are getting a clear view here from practitioners that everything should be included in those Commissions. Would you also include some of the alternative medicines that people are now using much more, such as homeopathy and Chinese herbal medicine clinics? Would you say that it should be an all-encompassing Commission for looking at Care Standards, or would you say some of those should be excluded? I particularly ask this because some people like to go to those services because they have got nothing to do with the NHS at all.

(Miss Perry) I think that there are two separate issues, from my point of view. Number one: if you are going to regulate the private and voluntary sector, it seems sensible, in terms of the experience we have had of the problems that occur when different bodies do it, to try to bring it together. I think that there is an issue about tagging it on later, and that we should see that as a very comprehensive review, rather than a tag-on, and I think that point is very well made. So our view is that all of the areas which, and I think there does need to be further work, to cover your point about what areas should be covered, I think we need to look at that in more detail, but everything that is deemed, through whatever process we go through, to determine those, should come under a single body. I think there is though an issue also about some lack of clarity, at the moment, who these Commissions for Care Standards are going to be accountable to, and I think there is some concern—sorry.

(Mr Mitchell) I think the White Paper is clear, that these Commissions for Care Standards are statutory bodies, accountable to the Secretary of State for Health.

(Miss Perry) Alright. I just thought that they would not all go immediately to the Secretary of State for Health and that they might, therefore, have ...

(Mr Mitchell) The membership structure is to be determined in framing legislation, but all the members will be appointed by the Secretary of State for Health, and they will be directly accountable, as statutory bodies, to the Secretary of State for Health.

(Miss Perry) Much like health authorities are now.

(Mr Mitchell) In a way; they will be non-departmental public bodies, technically. I think the other thing just to be said about them is that they need to be thought of as more than just replacing the registration and inspection responsibilities in relation to residential homes and nursing homes. As is made clear in the White Paper, the scope of services brought within the scope of regulation by the envisaged legislation will be significantly more than that, and the Commissions for Care Standards will, for example, have a very extensive range of responsibilities in the children's services, including, for example, private fostering agencies, and they will have responsibility for regulation of domiciliary care, to agencies providing domiciliary services. They are going to be bodies with a wide waterfront of regulatory activity to undertake. It is why Ministers have decided that they did not want to just tag on the independent acute staff, as was, in a sense, what happened, if you like, in the Registered Homes Act, they did feel that, rather than coming out and saying, in November/December, in a White Paper, that not only will this new regulatory regime apply to residential homes and nursing homes and children's services, and so on, but they will do all this independent acute stuff as well. And it was felt that there was a need for a more thorough review of some of the complex issues about that sector, to see how regulation should be undertaken, who should do it, and, after you have answered all that, what organisational structure do you put it under. And, at that point, you get to the question, if you are creating eight new statutory bodies for regulation of social services and nursing homes, is that the appropriate point to lodge the regulatory responsibilities for acute health care.

80. Can I go on to another institution which is going to be set up, which was briefly mentioned before, which is the Commission for Health Improvement, which is going to carry out local reviews and do some trouble-shooting, to ensure that there are quality services provided. In the Health Bill, in the House of Lords, it seems to be suggesting that it is going to have no jurisdiction outside the NHS. I wonder if that is the case. Particularly I would be concerned about NHS patients who were treated in the independent sector, and that might be particularly relevant in mental health, but in other areas, too?

(Mr Staniforth) If I could come in on that one, Chairman. The Commission will have a remit which is wide enough to allow it to look at services provided on behalf of NHS bodies within the independent sector, so NHS patients treated under contracts, or whatever arrangements, in the independent sector will be covered by the Commission. But its primary focus is intended to be on the NHS and not as a regulatory body for the independent sector where it is treating privately funded patients.

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Julia Drown Cont]

81. And so, if somebody was privately funded for inpatient care, laser treatment, day patients, even privately funded for mental health services, they would not be covered by the Commission for Health Improvement?

(Mr Staniforth) Certainly not at this stage. It may be an issue further down the track, but Ministers have been very clear that they see the primary responsibility of the Commission in the first few years as being focused on the NHS and patients funded by the NHS. I would want to make sure that it concentrates on that and does not dissipate its energies too far.

82. Can I just pick up a point on regulation within nursing homes. Currently, there are around 60,000 qualified nurses working in nursing homes, and that is a requirement of registration. It could be argued by some that that statutory requirement could be relaxed, and I wondered what your views would be on what the implications for the patients in those homes would be, and the implications for the NHS as well, in terms of the numbers of nurses that might make available?

(Mrs Morton) I think, what we have got to be very careful about is that we do not end up with nurse-managed care instead of nursing care. To relax it, we would probably have to end up saying that you have got one qualified nurse on duty at any one time; if that is a large home, you have a lot of staff to manage, a lot of clinical input, a lot of medication to monitor, I think that would be nurse-managed care, not nursing care. I think there is some misunderstanding about nursing care, and there is a mix-up as to whether or not it is social care. Nursing care is not necessarily, in my view, about giving an injection or dealing with a wound, it is about the promotion of good health, it is prevention of ill-health, assisting people with recuperation and rehabilitation, wherever possible, and if the patient is no longer able to take active treatment then it is assisting them either in the best quality life possible, within their disabilities, or assisting them to a comfortable death, within the scope of their illness.

Dr Stoa

83. I would like to address a question to Mr Staniforth, about statutory protection of titles. You appreciate that this Committee is very concerned with patient protection and ensuring that patients do get the best possible deal, whether it be in the private sector or the public sector, but I am particularly concerned about the private sector for this particular question. The Consumers' Association, quite rightly, says that most consumers will have very little insight about professional regulation and will assume that a practitioner working in a private hospital or clinic is appropriately trained or skilled; in other words, a patient seeing the word "doctor" will assume that person is registered with the GMC, a patient seeing the title RGN will assume that that nurse is registered with the UKCC. But the Chartered Society of Physiotherapy has sent in evidence saying they are very concerned about the absence of protection of the titles "physiotherapist" or "physical therapist"; those titles, I gather, can be used by virtually anybody that wants to. And they are further

concerned that physiotherapists who have had their chartered status withdrawn, sometimes for disciplinary offences, or whatever, can, legally, openly advertise their services as physiotherapists in the private sector. Now what I want to ask is what plans does the Department have to introduce statutory protection of titles to increase consumer protection?

(Mr Staniforth) I have to say that there are plans on this front, which is, Government intends to bring forward for consultation proposals for legislation to replace the current Professions Supplementary to Medicine Act, and, in that, to include proposals for the protection of common professional titles for key health professionals. So I hope that, when that consultation process is through and any necessary changes are made, that will help to allay the concerns which, quite reasonably, have been raised by a number of bodies.

84. So you feel that this is being taken up sufficiently at the moment for the procedure to go through without too much difficulty?

(Mr Staniforth) As I say, we are planning to consult on this, with a view to sorting out this particular issue. I do not know, Robin, whether there is anything you would want to add.

(Mr Heron) It was an issue which came out when the current Act was reviewed, it was an issue which came out and will be taken forward, as a Part 2, to bring in amending legislation. So it is in hand and there will be some consultation beforehand.

Mr Lewis

85. Looking at the issue of pay beds within the NHS, it would be accepted that pay beds generally are managed within the framework of the NHS and yet are regulated outside of the NHS. Is that justifiable, do you think, that although it is managed within the general management of the NHS Trust yet the regulation is outside of that; is that sensible, or reasonable?

(Mr Staniforth) I do not think, at the moment, most pay bed units are regulated outside, they would be part of the NHS Trust itself, most pay beds and pay bed units, and, certainly, it is our intention that pay beds within Trusts will be covered by clinical governance and Commission for Health Improvement regimes, when those are fully introduced; we would see them as part of the whole Trust organisation.

86. So the current situation is that they are treated as part of the NHS for the purposes of accountability?

(Mr Staniforth) Yes.

(Miss Perry) As distinct from a private facility on an NHS site, and that is, I think, one of the points I was alluding to right at the beginning, where there is huge confusion. If you have got a hospital that has a few, differing numbers of beds that they would designate as pay beds, that do not even have to sit in the same part of a hospital but have special regulations within the Health Service, but the patient is technically a private patient within one, then they are covered by the NHS and the complaints procedure covers them as well. If you have got a

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Mr Lewis Cont]

hospital that is a private hospital sitting on an NHS site, that even if the asset might be owned by the NHS, or not, those patients are not regulated by the Act, but they are not covered, for example, by NHS complaints procedures. So there are anomalies, whichever way you look, that need to be unravelled; which is, I think, back to your point about why, I would imagine, Ministers would want to not see this as a tag-on issue, because it is so complex. It does need a really thorough review.

Chairman

87. Can I ask, at this stage, Ivan, before you pursue this, for some clarification about the current monitoring of practice within NHS hospitals by part-time consultants who do transfer patients between their private practice and their National Health Service practice. Because, certainly in my time involved with the Health Service, and as a health authority member, I have had, on many occasions, raised with me concerns by staff at the way in which their time was being used, NHS time, public, state-provided time, effectively, for private patients, for example, where operating time was being used, and I am sure you will have come across this. Who actually monitors this, in an objective way, because, clearly, it seems to me that within the Health Service at the present time the system is not properly monitored; are there any kind of objective looks from the outside at this kind of problem, where allegations of this nature are raised? And this may not have been an issue in your area, Miss Perry, but I wonder what your thoughts are, from the Confederation point of view, on that?

(Miss Perry) I am not sure that I can speak for the Confederation on this point, because I have not discussed it particularly with the full membership. But a personal perspective, in my experience, is that there are big differences between arrangements that are made with a private sector provider who owns the site that, for example, will use NHS operating facilities, and it is in the interests of the general manager of that hospital, when they are setting up their agreement, to make the agreement very clear, and not at the NHS's cost. In fact, I think, certainly in the ones that I have had some experience of, one of the reasons that you might enter such a complicated arrangement is in order to draw income for your NHS patients, so that it is a situation of benefit to both sides.

88. I was thinking more where a part-time consultant is, for their own interests, switching the status of a patient between the NHS and the private sector, often whereby they have seen the patient in a private consultation and then, I am not saying they may have treated or they may not have treated, but, I have come across a number of cases where the allegation has been that the patient has gained benefit within the NHS as a consequence of coming through the private sector?

(Miss Perry) Again, I think that this is an area, it is not an expertise of mine and obviously it does need to be looked at thoroughly, where the suggestion is that this kind of thing can happen.

89. Yes, but who is best to look at it, that is the point I am making, who is best to look at it? In our discussion about the future model of inspection and regulation, where best do we slot the requirement to look at this kind of issue, this kind of allegation?

(Miss Perry) I think perhaps the Federation could take that away and consult its members, to the extent to which it feels that this is a problem, and what systems exist in places to monitor and measure it; and I am sure they do it, I am just not equipped to bring them here to you today.

90. Would you be willing to take it on and come back to us?

(Miss Perry) Of course we would, yes.

91. Obviously, we will be on this inquiry for a little while yet. I would be very interested in what your thoughts are on that?

(Miss Perry) Yes, certainly.

(Mrs Morton) May I just respond to that. Within the Act, there is a requirement, when registering a premise, for them to state clearly where it is they are going to get their services from; that does not mean that they do not get their services from other areas as well, in a cost-effective manner, but there is a requirement within the Act for them to spell out where they are getting some of their services from, if they are not providing them on site.

Julia Drown

92. Just to clarify, was Mr Staniforth saying that the Commission for Health Improvement would look at pay beds in the NHS, so that they would be coming and doing trouble-shooting on privately paid for care in the NHS but they would not be going to look at privately paid for care outside the NHS?

(Mr Staniforth) Yes. I think, if you are looking at pay beds which may often be scattered throughout a hospital, it will be very difficult for the Commission, or for clinical government arrangements, to exclude those, because they are such an integral part of the whole Trust organisation; so they would be part of the Commission's remit, in looking at a Trust.

93. But would they accept a query from private patients who were worried about what had happened to them when they had been going through an NHS hospital?

(Mr Staniforth) Would the Commission accept a query?

94. Yes?

(Mr Staniforth) I think I would need to come back to you on that point, if I may, I think I would like to just take some advice on that point.

Julia Drown: Thank you.

Mr Lewis

95. It is again about the status of people working in the private sector. If somebody, a doctor, was working in a private patient unit of an NHS hospital, is there any possibility that that individual would not be actually also an employee of the Trust, so could the doctor be employed entirely separately from the Health Service?

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Mr Lewis Cont]

(Miss Perry) They could be. I think that, usually, to my personal knowledge, when private sector facilities on an NHS site are set up, one of the reasons for doing that is so that their consultants will be able to be on site more often, and therefore the assumption behind that, to me, means that they tend to accept that those consultants will use that facility and therefore be shared, have some sessions which are NHS and some hospital. But I do not think there is anything that would stop a private hospital employing their own private medical staff, whether the hospital was on or off an NHS premises.

96. You say it is unlikely, but it does happen?

(Miss Perry) I do not know the frequency.

(Mr Staniforth) I think it may happen a little more in the mental health area than perhaps it does in the acute care area, where I think most consultants are employed by either the Trust, or by a Trust in the vicinity, and work on a sessional basis in the private sector.

(Miss Perry) That is right.

97. Can I raise just one other issue, in the relationship between, it can be hospital doctors or it can even be GPs, in the context of the health authority and the relationship with the private sector, because there is also evidence, I think, of situations of referral from GPs, from hospital doctors, who have a commercial interest in, for example, a private nursing home. And I just wondered, again, are there any mechanisms, any systems, which evaluate what is happening in terms of that interaction; is there any way of monitoring referral patterns? If a doctor clearly has a commercial interest in a private sector nursing home, a private health care company, and who is then in a position to refer and benefit in that way, is there any system that monitors them?

(Miss Perry) Yes. The Health Service have got a number of Codes of Conduct, all under the heading of probity, in which any employee of the Health Service is supposed to declare any interests they have, in taking an action that might subsequently benefit themselves. If you are saying to me, do all hospital doctors have an absolute, thorough knowledge of that requirement of them, I think that I would have to go back and ask the membership what their view was. As to general practitioners, the situation there is slightly different because, of course, they are independent practitioners and not, as you know, employees, in the way that NHS hospital consultants are. And this issue was raised in relation to GP fundholding, where the practice might have a budget for the placement of older patients and could, potentially, those placements, go, as you explained, to facilities in which they had an interest. And one of the issues with the change from GP fundholding into primary care groups is that this issue, in the latest letter that came out from the Minister, is very clear about how, as these primary care groups develop, these issues need to be very openly confronted, we need to have mechanisms to ensure probity, so that all those regulations are followed.

Chairman

98. Can I just put to you, and put it to Mrs Morton, the concerns I have had over a period of years about the involvement of doctors in the nursing home sector, prescribing in homes in which they have an ownership. I am not sure quite what the current situation is, it is possibly anecdotal, but I have certainly come across two or three complaints from people who felt that their family members were being overmedicated by a doctor in ownership of a particular private nursing home, where it was possibly saving that nursing home money on staffing levels, by virtue of the overuse of certain drugs. It is anecdotal, but this is presumably an area that you would be extremely concerned about, but it illustrates the link that Ivan had a concern over, where there is a relationship between a practising doctor and some private facility of the kind that he has described?

(Mrs Morton) If it is the person in charge who is a doctor, he is not allowed to prescribe for the patients.

99. No, it was not; he was an owner.

(Mrs Morton) If we knew that a doctor had an interest in a business, we would not expect him to do any prescribing for those clients within the home.

100. For obvious reasons, which I have illustrated?

(Mrs Morton) Yes.

Mr Gunnell

101. If we move on directly to complaints procedures, what role do health authorities or community health councils have in relation to complaints about the Health Service outside the NHS, health care which people have received which is outside the NHS, whether it is on NHS premises or not?

(Mr Staniforth) I think, if I can start and I am sure colleagues may want to add. In general terms, if there are complaints which relate to the conditions for registration of an independent health care provider, for instance, there is activity going on which would appear to breach the conditions of registration, then, clearly, the health authority, as the registering body, has a role and responsibility to investigate those complaints. Similarly, an NHS patient who has been treated in the independent sector has access to the NHS complaints procedure just as if he, or she, had been treated in an NHS hospital. But complaints about the treatment of an individual, where that has been paid for privately, the health authority does not have a role in considering those complaints, and the complaints obviously are taken up with the private hospital or against the consultant, or the clinician, who might have been the subject of concern. So that is the general position. I do not know whether Claire Perry or Joan would want to add anything to that.

(Miss Perry) I think that there is an expectation on the part of patients that when they go into a private hospital they have the rights to complain that they know exist in the NHS; certainly that is an experience within our health authority. I know of a current case, at the moment, where the parents have lost a son and they are as concerned about the ability for the

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Mr Gunnell Cont]

hospital to provide as they are now complaining about the health authority's lack, as they see it, of support in furthering their complaints.

102. But the same would be true when people complained to community health councils?

(Miss Perry) Yes.

(Mr Staniforth) Yes, they do not have a remit in relation to the independent health care providers, they are NHS bodies looking at NHS provision and facilities.

103. And the Health Service Ombudsman also has no remit in the private sector?

(Mr Staniforth) Not in relation to care which is provided under a private contract, privately funded care. Clearly, if it is an NHS patient who has followed through the complaints procedure then, at the end of the day, the Ombudsman would have a role, if that were necessary, but not in relation to a privately insured, privately paying patient in an independent hospital.

104. But there have been cases where he has had a role where, for instance, the NHS has transferred the person, or encouraged the person, to transfer to the private sector?

(Miss Perry) The Ombudsman does have a case for NHS funded patients, where the health authority might have a contract for the provision of service in the private sector. For example, termination of pregnancies, if there was a complaint to be made but the termination occurred in a private clinic, if it was the NHS that had funded that care then there would still be the same complaints procedure and rights, ultimately, to the Ombudsman.

105. Do you think this area needs further clarification, so that patients know, at any rate, who they are entitled to complain to?

(Miss Perry) Yes.

(Mr Staniforth) Again, if I can just kick off briefly, I think this is an area which, when we come to consult on future regulatory arrangements, we will want to take views on how best to ensure that there are clear, proper and appropriate complaints procedures for patients in the independent sector, in which everyone can have confidence.

(Mrs Morton) At the present time, under the Registered Homes Act, there is a requirement for registration and inspection and health authorities to follow up complaints for all clients with mental health illness. There is an issue there where we are actually monitoring people who are in homes against their choice, if you think of some of the people in the forensic psychiatric units, and, although they will go through the hospital's procedure, they have a right always to go through the health authority for complaints. The issue then is if we do not act appropriately they have the right to take that further, on behalf of a complainant, against the inspection units, but the issue often is that the outcome is not a satisfactory outcome and it therefore would be much more appropriate to have a body that somebody could take that finally to, for some real judgement.

Chairman

106. Sorry, are you talking about people there who are placed by the health authority, or are you talking about people under section, or both?

(Mrs Morton) They could be both. Can I also say, there is an issue about, people who are placed by health authorities are not necessarily placed within the same area, or given area, they could be at the other end of the country, and monitoring is not easy for the health authorities either.

Julia Drown

107. If we are looking to the privately funded patients, currently, independent hospitals do not have to deal with any aspects of the complaint which relates to their medical care provided by the consultants there. I wondered whether you felt that private hospitals should have a responsibility to deal with complaints about an independent doctor who has got admitting rights to hospitals?

(Miss Perry) I think the view of the Confederation is that we need to look in depth at this whole area, rather than to give an answer to that very relevant question now; and we are pleased to hear that the consultation that is going to take place will cover this area. I think we acknowledge that there is a need to have a complete overhaul of the way complaints are dealt with in the private sector, and we will then canvass the views of our members as to where best that might sit, but we have not done that, at the moment.

(Mr Heron) Briefly, just coming back to the role of the GMC in all of this, under the current arrangements, I think, any person who has worries or doubts or information about a doctor's performance in the way they have been treated can actually go to the GMC themselves.

Dr Stoate

108. Just a couple of things. You have already said that the Ombudsman service does not really cover the private sector in quite the way that it covers the NHS sector, but do you think there should be an Ombudsman service available to private sector patients?

(Mr Staniforth) I am not sure whether it would be appropriate for the Ombudsman, as currently constituted, to take that role on; he is, obviously, a statutory officer of Parliament and there to look at problems in the public sector in the NHS. But I do think there is probably a case for some clarity about where a complainant who is dissatisfied with the response he, or she, gets from the private sector provider could go for a further independent review of that. Now how best you might achieve that, I think, is something on which, again, we would want to seek views in consultation, but I think it is a real issue, as to how best to achieve that.

109. Chairman, can I go back to something Mrs Morton said, it is rather important, and that was that you were talking about you would not expect a doctor who owned a nursing home to do any prescribing or any medical care in that home; is that what you were saying?

25 February 1999]

MR MARTIN STANIFORTH, MR STEPHEN MITCHELL,
MR MARTIN BROWN, MR ROBIN HERON,
MISS CLAIRE PERRY AND MRS JOAN MORTON

[Continued]

[Dr Stoaite Cont]*(Mrs Morton)* Yes.

110. There is a difference here, because my understanding is that there is nothing at all wrong with a GP owning a private nursing home and providing medical care, provided that is declared to the GMC and provided it is declared to the patient as well. So my understanding is that it happens quite frequently. Now I may be wrong on that point, but I think it needs clarifying?

(Mrs Morton) I cannot argue with that, because I do not know that. My perception is that we would not expect a general practitioner who actually owned a home and had a business interest in it to be prescribing care for the clients within it.

Dr Stoaite: Because my understanding is that it happens all the time, and, certainly, from what the Chairman was saying, there is anecdotal evidence of that going on. I wonder if it is something we need to take further evidence on, because I think it is—

Chairman: You are not setting up a Private Care Home yourself?

Dr Stoaite

111. I certainly would do no such thing, Chairman, and would never dream of doing so.

(Mrs Morton) I would happily do some work on that and bring some further information back to the Committee on it.

Chairman

112. Thank you. Can I just ask one question, that may have been answered already but I must have missed it. We talked about private patients in NHS pay beds, do they have access to the NHS complaints procedures?

(Miss Perry) No; not private patients in NHS pay beds, but NHS patients in private hospitals do.

113. Yes, I think I understand it.

(Miss Perry) It is where the funding sits, and if it is funded by the health authority then you have access to health authority systems, but if it is in a Health Service facility but funded by an individual, there are not the same rights.

Julia Drown

114. There is just one other thing, and that is on information. Do health authorities collect information on what is happening to patients where they have been seen privately. Does your health authority try to find out from Trusts what they are doing for your patients privately?

(Miss Perry) Sub-contracting. We would be aware of any patients of ours who had been treated in the private sector; we would not expect to place a contract for NHS treatment with a Trust who then sub-contracts it to the private sector without our knowledge, absolutely not.

115. But you would not find out what was happening, say, if somebody was doing tonsil treatments privately for your patient, who was paying for them privately?

(Miss Perry) No.

Chairman

116. If my colleagues have no further questions, can I ask, do any of our witnesses have anything they want to add, that there are issues that perhaps you feel we ought to be aware of that we have not picked up on, so far?

(Mr Staniforth) I think Mr Brown would like to make a couple of points.

117. You are making a late debut, Mr Brown?

(Mr Brown) Thank you very much, Chairman. It is just a point of information in respect of complaints procedures, particularly for patients who are in mental health settings, in that those patients that are detained under the Mental Health Act, of course, would be able to complain to the Mental Health Act Commission. As you will be aware, the Government is currently undertaking a review of the Mental Health Act, and one of the issues that the expert group that is looking at that is considering is whether the role and remit of the Commission might be extended to cover beyond just those people who are detained.

Chairman: If there are no other points that anybody wants to add, can I thank you for your help. You have agreed to come back to us on one or two points. It may well be, having looked at the evidence you have given, we need to write to you further, to clarify a few points, or ask about additional issues that we may not have raised. But can I thank you, once again, both for your written evidence and for your co-operation this morning. We are most grateful to you. Thank you very much.

*25 February 1999]**[Continued]***Supplementary memorandum by the NHS Confederation****PRIVATE AND INDEPENDENT HEALTHCARE (PM 46A)**

When Ms Claire Perry gave evidence to the Select Committee on behalf of the NHS Confederation, during its investigation of private and independent healthcare, she was asked about the issue of consultants gaining preferential access to NHS in-patient and day case treatment for their private patients.

Following consultation with member trusts, the NHS Confederation believes that systems to monitor activity in NHS operating facilities are both robust and properly monitored. All patients operated on during NHS sessions are pre-booked on the basis of their position on the waiting list together with an assessment of clinical urgency. The status of patients (NHS or private) would be identifiable at the point of booking and via audit trails.

The NHS Confederation does accept that private patients are able to gain preferential access through the purchase of a private outpatient appointment with a NHS contracted surgeon. Patients seen in this capacity may then be placed on a NHS waiting list on the basis of clinical priority, effectively bypassing the waiting list for outpatient appointments. This practice is in accordance with the statutory duty of the NHS and clinicians and managers, while recognising the inequity of the practice, are unable to handle these cases in any other way. Changes to this practice would require, we believe, amendments in secondary legislation.

*15 March 1999***Letter from the Parliamentary Clerk, Department of Health, to the Clerk of the Committee****THE REGULATION OF PRIVATE MEDICINE AND OTHER INDEPENDENT HEALTH CARE
(PM 77A)**

At the evidence session on 25 February the Committee raised two issues on which our officials promised to provide further information.

The first was whether information is available about the cost to the NHS of treating patients after "mistakes" have been made in the private sector. Hospital Episode Statistics include details of the numbers of patients who are admitted to NHS hospitals for corrective surgery but the numbers are not broken down into those who received their original treatment in the private or public sector, and consequently the costs to the NHS of treating patients originally treated in the private sector cannot be identified.

If the private sector cases could be identified it would still be difficult for NHS costs to be recovered. Whilst we are aware that some insurers are sensitive to the argument that where a policy is sold for total care it should cover total care wherever it is delivered (and they would, therefore, consider meeting NHS costs if the legislative basis for charging was in place) other insurers would be reluctant to pay NHS costs without a finding of liability against them. Within the NHS corrective surgery is sometimes required not as a result of any identifiable mistake but because of complications which cannot be clearly related to any specific incident. In cases of alleged medical negligence this is often the point of conflict and in those cases the Courts are asked to adjudicate and apportion blame. A scheme which would increase the number of cases coming before the Courts is unlikely to be well received.

The Committee may be aware of the proposal, published in a consultation document by the Law Commission, that the NHS should be able to recover its costs in all cases of successfully actioned personal injury. In other words whenever a patient obtains compensation not necessarily as the result of legal action, in respect of an injury which required hospital treatment then the NHS could also recover its costs from the party paying compensation. The Government is committed to considering this proposal. Should it be accepted and the necessary legislation put into place then the NHS would be able to recover costs in cases where patients need treatment as a result of personal injury in the private sector, providing the patient seeks and receives compensation in respect of the incident.

The second question was whether the Commission for Health Improvement would accept a query from a private patient who was worried about their care while being treated in a pay bed in an NHS hospital. The general position is that the Commission will review arrangements to monitor and improve the quality of health care provided to NHS patients, and conduct investigations into service problems. The clinical governance arrangements to improve the quality of care would be organisation-wide and therefore apply to patients in pay beds as they would to those in NHS beds. Where a member of the public has concerns about the quality of their care provided by an NHS organisation, be they in a pay bed or an NHS bed, they would be free to raise these concerns with the Commission. The Commission would consider these concerns and may decide to take action in one of a number of ways.

The Commission's primary focus will be on organisational systems rather than the care provided to individual patients. But where an individual complaint indicates a wider significant clinical problem in an NHS organisation the Commission may wish to follow this up. It might of course wish to draw some

25 February 1999][Continued

complaints to the attention of the appropriate body—for example, the Health Service Commissioner in the case of complaints about the care and treatment of individual patients or the appropriate regulatory body where there are concerns raised about the performance of individual clinical staff.

The Commission itself would be able to advance the place of an NHS Trust or a Primary Care Trust within its rolling programme of local reviews, if it felt this was necessary, as a result of concerns raised by the public about service problems that require continuing local action. In its local review the Commission would look for evidence that the organisation has systems in place to tackle these problems. It would report on its findings to the organisation concerned who could then request the Commission to conduct a more detailed investigation of underlying service problems that have failed to respond to local efforts. In that event the Commission would investigate further and develop recommendations for rapid action to help put matters right.

The Commission may also wish to raise patients' concerns directly with the appropriate Regional Office of the NHS Executive to check on progress made by the organisation concerned and to provide supporting evidence for the complaint. As a result, it might be agreed that the Commission investigate further. The Commission may also raise concerns brought to its attention by the public with the Secretary of State who will be able to direct the Commission to investigate where necessary.

In all this, it will be important to ensure that the Commission's help is targeted where help is needed most, that its approach is consistent with the objectives and priorities set for the NHS, and that the Commission operates with regard to existing NHS mechanisms for assuring quality and tackling local service problems. There are already well established arrangements within the NHS for tackling service problems and dealing with patient complaints. The Commission for Health Improvement is intended to complement these, not to be a substitute for them.

Finally, towards the end of the evidence session there was discussion about the access of patients in NHS pay beds to the NHS complaints procedure. The position is, in fact, a little more complex than suggested by the NHS Confederation, and the Committee may find it helpful to have a fuller explanation of the position: In general patients in pay beds cannot use the NHS complaints procedure to complain about the actions of the private consultant under whose responsibility they have been admitted. They can, however, use the process to complain about the actions of other NHS staff whose involvement in their care is part of their usual NHS duties. This would normally include junior doctors, nurses and any other directly employed staff of the Trust.

11 March 1999

THURSDAY 4 MARCH 1999

Members present:

Mr David Hinchliffe, in the Chair

Mr David Amess
Dr Peter Brand
Julia Drown
Mr John Gunnell

Mr Ivan Lewis
Mr Robert Walter
Audrey Wise

Memorandum by the Consumers' Association

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE. (PM 52)

CONSUMERS' ASSOCIATION

Consumers' Association (CA) is an independent organisation which has worked to seek improvements in the standards of goods and services made available to consumers for more than 40 years. CA is a charitable organisation supported by a membership of approximately 750,000 consumers.

Consumers' Association is probably best known for its consumer reports published in *Which?*, *Health Which?*, *Holiday Which?* and *Gardening Which?* However, CA also reaches more specialist audiences through publication of *Drug and Therapeutics Bulletin* (DTB) and *Consumer Policy Review* (CPR). DTB provides independent and rigorous evaluations of drugs and other treatments and is circulated monthly to over 110,000 doctors and pharmacists. CPR is published bi-monthly and aims to promote public discussion and debate across a wide range of consumer policy areas.

A large part of CA's work is directed at providing clear, unbiased consumer information and advice. This work is supported through publication of CA books and guides and on-line consumer information and advice provided through our *Which?* online service.

OUR EXPERTISE

Consumers' Association has a long history of campaigning for better healthcare services in both the public and private sector. This campaign is firmly rooted in our belief that consumers are entitled to access to good quality, safe, patient centred healthcare services and to information to enable them to make informed decisions about their health care. We are also committed to ensuring that redress systems are in place for consumers to use when things go wrong.

Consumers' Association has probably undertaken more investigations into private health care services than any other consumer group. This work has included investigations into services provided by laser eye surgery clinics, cosmetic surgery clinics, slimming clinics, and walk-in GP clinics. In addition to developing a thorough understanding of the regulatory framework within which the private sector operates, CA has a long tradition of going undercover in order to experience services exactly the way that ordinary consumers do. As with all our research, this undercover work is designed to the highest standard.

It can be very difficult to investigate in-patient services in either private or public sector settings. However, we are confident that our work on private clinics highlights important and relevant issues which are applicable across all sectors of private and independent health care services.

EVIDENCE

The evidence in this submission has been largely drawn from research undertaken in support of *Which?* and *Health Which?* reports. As part of our ongoing work on private health care services we have also met with representatives from the Independent Healthcare Association (IHA), BUPA and Royal College of Nursing (RCN). Copies of *Which?* and *Health Which?* reports referred to in this submission are attached for the committee's consideration—(appendix 1).

The Consumers' Association (CA) welcomes this opportunity to provide evidence to the Health Select Committee inquiry into the regulation of private and other independent health care provision.

4 March 1999]

[Continued]

BACKGROUND

In 1996–97 there were 348 establishments in England registered under the Registered Nursing Homes Act 1984 as private hospitals, homes or clinics¹. Expenditure on private health care in the UK in 1996 was approximately £2.35 billion.²

Private and independent health care services are increasingly becoming a day-to-day part of our lives. In some areas this is a result of a decline in NHS provision. For example, the nursing home sector for the elderly is now substantially greater than that of continuing care provided directly by the NHS³. In dentistry, although the majority of patients are seen on the NHS, there has been a gradual shift to private practice over the years with one in four adults now using private dental services.⁴ There has also been developments in walk-in GP services, and advancements in clinical practice has meant that more and more minor surgical procedures are available in clinic type settings. Many of these services currently fall outside of the Registered Nursing Homes Act 1984.

Whether people use private or independent health care services as a result of the lack of availability of NHS funded care, or out of personal choice doesn't matter. It is our view that all patients should be afforded the same benefits and protection.

REGULATION OF PRIVATE HEALTH CARE

The regulatory structure within which private and independent health care services operate is complex. There are numerous regulations and guidelines covering various aspects of the service including health and safety, professional conduct of doctors, and advertising.

Unfortunately, although the regulatory structure is multifaceted, the overall framework for the regulation of private health care is fragmented and largely ineffectual, particularly with regard to safeguarding the interests of those who use these services.

NURSING HOMES ACT 1984 AND GUIDELINES

Most independent health care provision is regulated and inspected under part two of the Registered Nursing Homes Act 1984 which legally defines these services as "nursing homes". The services covered are: independent acute hospitals; independent psychiatric hospitals; hospices for the terminally ill and any premises (unless specifically excluded) where:

- surgical procedures are carried out under general or local anaesthesia;
- pregnancies are terminated;
- endoscopy is carried out;
- haemodialysis or peritoneal dialysis is carried out; or
- specially controlled techniques are used, such as the use of lasers.

Registration and inspection of premises registered under the Act is undertaken by local health authorities.

Since implementation of the 1984 Act further guidance on registration of premises has been developed by Nahat (National Association of Health Authorities and Trusts, now the NHS Confederation). This guidance is outlined in a number of publications, including a 1985 Handbook on the registration and inspection of nursing homes, and a 1993 supplement entitled "Independent Acute Hospitals—Supplement to the Handbook on the Registration and Inspection of Nursing Homes." Further guidance was issued in a 1995 publication entitled "Raising The Standard".

Much of the Nahat guidance has been directed at supporting registration and inspection activities and providing clarification about the kind of services which should be appropriately registered under the Act. For example, in the 1993 supplement to the Registration Handbook, Nahat concluded "... the term 'invasive procedures' captures the point at which the question arises whether those procedures should be drawn into a requirement to register. Such procedures are likely to relate to one or more episodes of a treatment." It was also concluded that there is "no doubt that the following procedures are required to be the subject of registration."⁵

- day surgery under general or local anaesthetic;
- laser treatment by class 3B or 4 laser;

¹ DoH Statistical Bulletin 1998/14, Private hospital, homes, and clinics, 1998.

² The NHS is not an Island, Public-private relations in UK health care, Justine Keen and Nicholas Mays, 1998.

³ Nahat, Raising The Standard, Management Standards for the registration and inspection units of health authorities.

⁴ BDA Media and parliamentary briefing 'Do we need more dentists' August 1998.

⁵ Nahat, Independent Acute Hospitals and Services, Supplement to the Handbook on the registration and inspection of Nursing Homes, 1993.

*4 March 1999]**[Continued]*

- invasive investigations or treatments (eg colposcopy, hair transplants, in-vitro fertilisation);
- x-ray procedure involving injection of dyes/radio opaque substances;
- lithotripsy;
- vasectomy; and
- hyperbaric oxygen therapy.

LIMITATIONS OF EXISTING REGULATIONS

The stated purpose of the registration and inspection system is to protect patients and maintain standards⁶. It is CA's view that the 1984 Act and subsequent guidelines no longer support achievement of these core objectives.

As its name indicates, the 1984 Act was designed with the traditional nursing home or acute care setting in mind. As other private health care services have come on stream they have been largely accommodated within the Act through a process of "bolting-on". The net result is a situation where the core purpose and thrust of the Act is not particularly relevant to the range of services which are included within its scope.

The incremental approach by which the Act has been updated has also resulted in a somewhat ad hoc approach to the development of criteria for determining what services should be included. In some instances these criteria are very specific and narrowly defined, for example, premises offering vasectomies must register. In other instances, more general criteria are identified, for example, the inclusion of premises where "invasive investigative" procedures are undertaken.

This approach has resulted in inconsistency in the interpretation of the regulations and health authorities (as well as service providers) must sometimes make pragmatic judgements about whether registration is necessary. For example, we have been advised by one health authority that they require clinics which offer laser hair removal services to register, but that they are aware of other health authorities which do not. We also were told by one clinic that they register all sites where collagen replacement therapy is performed although they do not believe that this is an industry standard⁷. In addition to concerns about inconsistency, we have a general concern that there is nothing to ensure that premises which should be registered under the 1984 Act have actually done so.

As part of our work on walk-in GP services, we are aware that there has been some debate about whether these clinics should be registered. It is our view that the potential for minor surgical and investigative/diagnostic work undertaken in GP walk-in clinics in such that they should be required to register.

However, the main weakness of the 1984 Act and subsequent guidelines is that they do not prescribe any standards with regard to the quality of services provided. The registration and inspection process does not provide health authorities with the power to look at clinical practice or outcomes, take a view on whether patients are being provided appropriate information about the procedures offered by the clinic, or consider whether there were adequate patient redress systems in place.

In addition, although health authorities require that applicants provide "the full names and qualifications of any resident or non-resident employed practitioner" they do not have any influence over the choice of practitioners with regard to expertise and skills. In this regard, it is our view that the only real benefit to registration under the 1984 Act is to the clinic, which advertises it as a sign of quality.⁸

Serious consideration must be given to arrangements for registration and inspection of Nursing Homes provided for under the 1984 Act. In particular, the Act and Guidelines must be reviewed to establish whether they provide an adequate basis for ensuring meaningful and effective evaluation of services with regard to patient safety and standards of care. Measures are also needed to ensure that standards are consistent on a national basis.

There is also a need to ensure that the scope of regulations governing private health care services are adequate with regard to consistent and clear criteria for identifying which services should be subject to registration and inspection requirements. These criteria must be comprehensive and consideration should be given to including non-invasive clinical activities which present a significant degree of risk. For example, premises offering general medical diagnostic services.

⁶ DoH, Regulation of Nursing Homes and Independent Hospitals—HSG (95)41, 1996.

⁷ Information drawn from telephone interviews with Registration and Inspection Unit Managers and representatives from Cosmetic Surgery Clinics, (11 Nov–25 Nov 1998).

⁸ *Health Which?* The Surgery Sale, October 1997.

*4 March 1999]**[Continued]*

CA has not considered specific organisational arrangements for implementation of more rigorous regulation of private health care. However, we do see that there are potential opportunities to improve standards, as well as inspection and evaluation measures, through existing organisational arrangements. For example, through the Commission for Health Improvement (CHI) and the proposed Regional Commissions for Care Standards.

PROFESSIONAL REGULATION

It is understood that the Committee is not considering the issue of self-regulation of professionals as part of this inquiry. However, for purposes of this submission it is important to highlight the deficiencies which exist with regard to control over representation of professional skills and expertise.

British Medical Association guidelines prevent doctors from promoting their services as individuals or claiming superiority over services provided under the NHS. Private Hospitals or clinics employing a practitioner will also usually require that they show evidence of registration with the GMC and are a fully paid up member of one of the medical defence Unions.

There are also two professional associations—the British Association of Aesthetic Plastic Surgeons (BAAPS) and British Association of Cosmetic Surgeons (BACS), but membership is voluntary and does not necessarily indicate that the practitioner has specific training and skills relevant to the area they are working in. For example, ophthalmic or ENT professionals may have extensive surgical experience but not necessarily in the specialist “cosmetic surgery procedures.”

However, any doctor fully registered with the General Medical Council (GMC) is entitled to set up in private practice. There are no legal restrictions on who can give medical advice or perform surgery other than the requirement that patients must not be misled about professional qualifications and proper written consent must be obtained for procedures. (By contrast, surgery on animals can only be legally performed by those who are formally qualified as veterinarians.)

Under the current arrangement, anyone can set up a private clinic—for example, a private cosmetic surgery clinic, call themselves a consultant, advertise for patients and even operate as long as they don’t pretend to be doctors⁹. While the Act and guidelines would require that this kind of clinic be registered with a health authority, it offers patients very few safeguards or assurances about the quality of clinical care provided.

Most consumers will have very little insight about professional regulation and will assume that a practitioner working in a private hospital or clinic (which is registered with the local health authority) is appropriately trained and skilled. Cosmetic clinics will often advertise that their surgeons are fellows of the Royal College of Surgeons (FRCS) but this on its own only establishes that the surgeon has basic training.

Consumers could be forgiven for assuming that practitioners wouldn’t be working in a particular area unless they were properly skilled, or that the premises wouldn’t be registered with a health authority if there was any question about professional competency. However, even if consumers are interested in learning more about the skill and background of a practitioner working in a clinic or private hospital they will have a very difficult time getting the level of detailed information required to make an informed judgement. For example, they will not be able to confirm how frequently the practitioner has performed a particular procedure before—or if they’ve performed it at all.

The lack of control over practitioners working in private and independent health care services is concerning. It is our view that the Committee must consider measures to ensure that services are provided by appropriately trained and experienced clinical staff. At a minimum consumers must have access to information about private health care services, including information about the experience that practitioners have in the procedures they are performing. We welcome the Government decision to make health authority inspection reports available to the public. However, we strongly urge consideration of further measures to ensure that detailed, relevant information is publicly available.

ADVERTISING CONTROLS

The vulnerability of patients using independent and private health care services is heightened by the dual “clinical and commercial” function of the provider and the lack of independent and objective information available. CA welcomed the Government’s decision to make health authority inspection reports available to the public. However, as noted these reports mainly offer limited information.

In this regard, many people rely on magazine adverts and brochures for information about clinics, procedures and qualification of clinical staff. Advertising of health care services is regulated by the Advertising Standards Agency (ASA) and there are specific guidelines developed to deal with cosmetic surgery. But evidence would suggest that these controls have not been effective and mis-representation of practitioner’s skills and qualifications is a common area of abuse. In a 1998 letter to the ASA, Professor

⁹ *Health Which?* The Surgery Sale, October 1997.

4 March 1999]

[Continued

Sharpe, president of the British Association of Aesthetic Plastic Surgeons wrote: 'Many of these organisations have been responsible for disfigurement and complications in patients through misrepresentation of their accreditation.'¹⁰

16 complaints about cosmetic surgery were upheld in 1996. However, there have also been numerous cases where clinics have not adhered to the ruling, and the ASA have been criticised for allowing private clinics to flout rules by continuing to run adverts that have been found to be misleading.¹¹ If the ASA is to play a role in protecting private patients from misleading and inaccurate claims then it is essential that it improves its performance with regard to ensuring that private healthcare providers comply with their rulings.

The July 1998 Independent Review Group Report on Silicone Breast Implants has also raised concerns about the lack of accurate information in adverts for breast surgery and recommended that women should be given a contact where they can obtain balanced, independent information about the benefits and risks of breast surgery. CA fully supports this recommendation and following publication of the IRG report we wrote to the Chief Medical Officer seeking assurances that the Group's recommendations would be implemented. However, we are not aware of progress on implementation of the IRG report recommendations.

QUALITY OF CLINICAL CONSULTATIONS

CA's investigations into service provided by private clinics has consistently found variability in the quality of information and advice provided to patients and lack of clarity between clinical consultations and sales activity. The Independent Review Group report on Silicone Breast Implants also raised concerns about the "varying standards of quality assurance among the variety of organisations in the private sector offering breast implant surgery recommended that a 'quality assurance system, including the sending of a routine letter to the women's GP and clinical audit procedures should be standard practice within such clinics.'¹² We wholly endorse the implementation of this recommendation and it is our view that its implementation that it should be incorporated into the regulatory framework governing private health care services.

Our researchers have found that staff responsible for preliminary assessments and examinations were not always clinically qualified and some initial consultations were very sales orientated. We also found a number of examples of unqualified staff answering questions about procedures and explaining risks and benefits related to specific procedures. In one instance, A CA researcher was asked to make a decision about laser eye surgery and pay a deposit before they had an opportunity to speak with qualified staff. We also found that some clinics agreeing to undertake unnecessary procedures, or procedures which would be of limited benefit to the patient.

We are also concerned about the practice of offering financial rewards for referrals. We are aware of advisory centres which claim to offer independent advice and referrals. We have not undertaken a thorough investigation into this practice but preliminary evidence suggests that some of these agencies may be acting solely for one surgeon or clinic; that they charge fees even when they have not provided a full service to the client; and that some claim to be free when in fact their fee is added to the cost of the treatment.

The following is a summary of the key findings from Health Which? and Which? Investigations—(copies of full reports are attached in appendix 1.)¹³

*Slimming Clinics: Health Which? February 1999**

Three CA Researchers attended appointments at nine different private slimming clinics in autumn 1998. (None of the researchers were obese).

- Five of the consultations were considered to be of poor quality;
- Drugs were given out at five of 10 appointments even though none of the researchers were obese, this is against the guidelines on prescribing;
- Doctors at most of the clinics seemed indifferent about the importance of informing GP's about medication given out;
- At one clinic, the only information about side effects of a prescribed drug was given out by the receptionist.

¹⁰ Guardian Newspaper 05/08/98.

¹¹ Guardian Newspaper 05/08/98.

¹² The Report of the Independent Review Group—Silicone Gel Breast Implants, 1998.

¹³ Not printed.

4 March 1999]

[Continued

Walk-in GP Clinics: April 1998 Health Which?

- CA sent three researchers posing as patients for consultations with GPs in various Medicentres. Each researcher visited five of six clinics included in our investigation.
- Many of the doctors visited by CA researchers failed to make arrangements for letters about the consultation to be provided to the patient's own GP.

A number of Clinic doctors did not take detailed medical histories or take steps to ensure that they all had the relevant information about our researchers problems.

A number of doctors prescribed medication without completing a physical examination.

Laser Eye Surgery Clinics: May 1998 Which?

Six CA researchers visited 11 clinics and hospitals to test the quality and thoroughness of initial consultations for refractive surgery. Researchers also visited opticians and asked for advice about eye surgery treatments.

Overall, the standard of advice and information provided by clinics and hospitals was good and most researchers felt they were given balanced information about the procedure. However: One researcher who had been briefed to say she was pregnant was booked for refractive eye surgery without being asked for full details about her health and medical history.

Another researcher was encouraged to book for treatment on the same day as his initial consultation. The Royal College of Ophthalmologists recommends that treatment should not be given on the same day as the initial treatment.

Cosmetic Surgery Clinics: October 1997 Health Which?

Two researchers visited seven cosmetic surgery clinics which advertised in women's magazines. One researcher was briefed to say she wanted liposuction on her thighs, the other to say that she wanted her breasts made smaller.

- At one clinic the consultation was held in a medical setting with someone who called himself or herself a "consultant" but who had no medical training.
- In response to questions about risks associated with the procedure, our CA researcher was advised that breast reduction was not a "major operation but a major decision."
- One clinic asked both researchers for a deposit for the surgery before seeing a surgeon.
- In another clinic, CA researchers were urged to purchase a "skin solution" costing £80—which they were told would improve the healing process following surgery. Upon analysis the skin preparation solution was confirmed to be basic antiseptic.

Slimming Clinics: March 1995 Which?

CA researchers visited doctors at four slimming clinics in central London.

- At one clinic our researcher was charged £25 and given a six week supply of a drug without being warned of its side-effects.
- At another clinic our researcher was charged £50 for a three-week supply of the same drug and told not to worry if she suffered any side-effects.

It is our view that measures must be implemented to ensure that patient consultations are conducted by qualified staff and that clinical consultations are clearly separate from sales and promotional activity. We also propose that referral and advisory agencies be required to advise consumers about any fee and commission arrangements or if they are acting on behalf of a sole clinic or clinician.

COMPLAINTS AND REDRESS SYSTEMS

Under current arrangements there are only two formal redress systems available to patients who use private health care services. These are the General Medical Council or the courts. In the majority of cases where patients experience difficulty with services neither of these options would be suitable. Patients can complain to the hospital or clinic where they have received treatment however there is no guarantee that their grievance will be considered or responded to.

4 March 1999]

[Continued

Some private health care providers do have in-house complaint procedures but this is not a formal requirement. There is no information regarding the number of establishments registered under the Nursing Homes Act 1984 which have in-house complaints procedures. In our investigations we have not found information about how to make a complaint about private health care services readily available.

Redress systems are an important quality assurance measure and it is important that patients have opportunities to provide feedback about problems or unsatisfactory experiences and that these views are taken on board. We believe that private health care services should be required to have in-house procedures in place and that patients must be given information on how to access these procedures. We also believe that information from complaints should be considered as part of the registration and inspection process.

In addition, the right to secure independent redress in the case of poor service provision is a key consumer principle. Consumers' Association recently lobbied for support for a proposed private member's bill to extend the Health Service Ombudsman's powers to cover private health care as well the NHS. This would bring private health care services in line with other service areas such as banking, funerals, real estate, building societies, investment services and legal services where Ombudsman schemes are already in place. A copy of CA's proposed bill is attached in appendix 2.¹⁴ We urge the Committee to consider this recommendation

15 January 1999

Memorandum by the National Consumer Council

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 56)

1. THE NATIONAL CONSUMER COUNCIL

1.1 The National Consumer Council was set up by government in 1975 to champion the interests of consumers of goods and services provided in the public and private sectors. We are currently undertaking a medium-to long-term project to look at regulatory issues in public and private health care. Our consumer tests of access, choice, information, safety, fairness, redress and representation are being applied in looking at different aspects of regulation of health services and the healthcare system.

2. DIFFERENT FORMS OF "REGULATION" FOR HEALTH CARE

2.1 The concept of regulation has different meanings in the context of health care in the UK. A framework for considering regulation could include:

- *regulating the market*—stimulating appropriate competition and protecting the interests of consumers (for instance in pricing and redress); ensuring openness and transparency in the public/private interface which often arises for NHS patients;
- *regulating services*—monitoring standards of care (for instance in public and private hospitals, in community services, in nursing homes and care provided through nursing agencies in people's own homes, in public and private general practice); ensuring treatments, processes and equipment are safe and effective; providing appropriate systems of representation and redress;
- *regulating products and medicines*—ensuring the safety of new products and technologies and promoting openness in approval processes;
- *regulating the people*—examining the role of, and issues in, professional self-regulation.

3. NCC'S FORTHCOMING WORK ON PROFESSIONAL SELF REGULATION AND DEPARTMENT OF HEALTH EXECUTIVE AND ADVISORY BODIES

3.1 A fragmented and potentially confusing "mixed economy of care" covers NHS, private and charitable provision. The relationship between public provision through the NHS and private health care is increasingly blurred. People using public and private health services are unlikely to know how the various systems work, or what provisions protect their interests. It is important in discussing issues in the regulation of health care to understand existing structures. The National Consumer Council is currently preparing two relevant reports.

Professional self regulation

3.2 The first report will be a descriptive overview of professional self-regulatory bodies and a discussion of issues in professional self-regulation, a subject important in both public and private health care. This work will be informed by a more general paper we are preparing on consumer issues in self regulation.

¹⁴ Not printed.

4 March 1999]

[Continued]

Department of Health executive and advisory bodies

3.3 Our second planned report lists and briefly describes Department of Health executive and advisory bodies, tribunals, task forces and reviews, which play a variety of roles in managing the workforce and protecting the interests of consumers of health care. Some are exclusively concerned with the working of the National Health Service, but others are relevant across the board, for instance the Human Fertilisation and Embryology Authority and the National Radiological Protection Board. These bodies operate largely out of the public eye. We believe it is important to look at their work as a whole, to understand where they play a role in both public and private sector health care. Among other themes to be considered in this report, we will explore the conflict of interest arising in the Department's dual responsibilities for protecting the public interest in various ways, and in promoting the health and pharmaceutical industries.

4. THE PUBLIC/PRIVATE INTERFACE

4.1 The Committee is looking at the regulation, monitoring and inspection of health care outside the NHS. We believe it is also important to look at what we call the public/private interface which consumers may meet when looking for services within the NHS. This interface arises when, for instance, NHS provision is limited or has been reduced. Chiropractic is a good example of health care which once was available in the NHS, but which is now limited or not available for some people. Consumers visiting an NHS practitioner may well be told they have no option but to use private services.

4.2 Another such interface arises for people seeking NHS dental care. It is common for such people to be told by their dentist that one option for treatment can be provided under the NHS, but another—perhaps “better”—privately. Similar situations arise for patients visiting their general practitioner, who may tell them, for instance, that waiting times will be shorter if they use private care.

4.3 We have suggested in a recent report on primary care groups that patients will need protection where general practitioners might have an incentive to suggest they use private care, to reduce pressure on the budget of a practice or primary care group or trust. (See NCC, *Consumer Issues in the Finance and Accountability of Primary Care Groups and Trusts*, December 1998, page 28). Similar protection may be needed when acute health care trusts offer private alongside NHS beds.

4.4 In such cases consumers need protection, for instance the assurance that they are fully and accurately informed about what they could—or should—be able to expect from the NHS and that they are protected against over-charging, especially where private services they have to use may replace those they once expected from the NHS.

5. COMPLAINTS AND REDRESS

5.1 In all our work on the provision of public and private goods and services, we are concerned that appropriate systems of redress should be in place. There has been a great deal of work in recent years on principles of good complaints procedures, both for the NHS, and more generally through the work of the Citizens Charter and Service First Units. (See, for instance, our 1996 publication *Putting it right for consumers*, a review of complaints and redress procedures in public services.) We welcome the Committee's intention to look at complaints procedures in private sector care and would be pleased to provide the Committee with further information or support in this area, if needed.

5.2 Our work on complaints procedures in the NHS shows that consumers often feel vulnerable and unable to complain about their health care, particularly in primary care where they are wary of damaging the doctor-patient relationship. We have also commented on consumers' need for support and representation in making complaints, and the problems of the costs for them in doing so. (See NCC, *NHS Complaints Procedures: the first year*, 1997.)

5.3 Users of private health care services do not have the same systems of protection as those using public provision. For instance, there is no ombudsman with a remit for private health care, and access to legal remedies may be difficult to obtain. In 1996 we published *Medical Negligence for Lord Woolf's Access to Justice Inquiry*. It is relevant in the context of private health care. We have also published *Settling consumer disputes* (1993), a review of alternative dispute resolutions.

5.4 We do not know what effect proposed changes in the civil justice system will have on access to various forms of legal remedy for consumers of private health care, with changes in the legal system. The current Access to Justice Bill proposes a combination of state funding and conditional fees which has yet to be tried out. It also proposes a new test for determining merit which will take account of availability of resources and the priority the state gives to funding medical negligence cases as opposed to other types of case. We will be giving detailed comments to the Government and the Legal Aid Board about the proposed legal aid changes.

4 March 1999]

[Continued

6. SOME RELATED ISSUES FOR CONSUMERS

Using health care products

6.1 Part of the growth in private health care is in the purchase of medicines or equipment. The “market” for health care products is growing. Some of this growth arises from the re-designation of medicines from prescription-only or pharmacy status to over the counter status. It is important that advertising of such products is not misleading; concerns also arise about the cost of products, particularly where they replace those previously provided under the NHS. Similar points apply to care provided by private clinics.

6.2 We note that cases regularly appear before the advertising standards authority about misleading claims for clinics and health products. We would welcome examination by the Committee of the extent to which firmer regulation is needed for the advertising of private health care services and products sold on the open market, and the extent to which regulation may be needed about their cost.

Long-term nursing care

6.3 We have submitted evidence to the Committee in previous Parliaments on our concerns about protecting the interests of people needing long-term nursing care. The Government’s social services White Paper (*Modernising Social Services*) sets out changes in the regulatory framework for nursing home care. It proposes a new system of voluntary registration for agencies which provide domiciliary care.

6.4 The White Paper is very weak, however, in its attention to private nursing agencies, saying only that the Government is considering how best to deal with their regulation. People in their own homes using private nursing agencies are especially vulnerable. Little is known about the numbers of people using such services, and their experiences of care. This is an area which needs urgent attention.

7. CONCLUSION

7.1 We welcome the Health Committee’s initiative in looking at the regulation of private health care. We believe there are important issues to be considered in terms of regulating both the individuals who provide such services, and the way they are marketed. We would welcome consideration by the Committee of issues which face consumers in negotiating the public/private interface between the National Health Service and the private sectors. As this memorandum shows, we have work in progress which we believe will be relevant to its Inquiry, and which we will pass to the Committee as it is finalised.

January 1999

Examination of Witnesses

MS CLARA MACKAY, Senior Policy Researcher, Health, MS SALLY WILLIAMS, Senior Health Researcher, Health Which?, The Consumers’ Association, MS JILL JOHNSTONE, Head of Policy and MS BARBARA MEREDITH, Senior Policy and Development Officer, National Consumer Council, were examined.

Chairman

118. Good morning, everybody. Can I welcome you to this morning’s session of the Committee and apologise for the slight delay in our starting. Can I welcome our first group of witnesses and particularly thank you for the extremely helpful information that you have given us in the written evidence. I wonder if I could ask you briefly each to introduce yourselves, say a bit about your organisation and your own role within the organisation. Ms Meredith, would you like to begin?

(*Ms Meredith*) I am Barbara Meredith from the National Consumer Council. I am Senior Policy and Development Officer there with responsibility for health and social services.

(*Ms Johnstone*) I am Jill Johnstone. I am Head of Policy at the National Consumer Council. The Consumer Council was set up in 1975 by Government to represent the interests of all consumers. We have a particular remit for disadvantaged consumers.

(*Ms MacKay*) My name is Clara MacKay, I am Senior Health Researcher in the Consumers’ Association Policy Division. I am accompanied today by Sally Williams who is a Senior Health Researcher on Health Which? Magazine. Consumers’ Association is the oldest and largest independent consumer organisation in Europe. We are independently funded with a membership of over 775,000 consumers. CA has a long history of campaigning for better health care services in both the public and private sector. This campaign is firmly rooted in our conviction that consumers are entitled to good quality, safe, patient centre healthcare services and to information to enable them to make informed decisions about their healthcare. We are committed also to ensuring that redress systems are in place for consumers to use when things go wrong.

119. Can I begin by asking you briefly to set out from each of your organisations the problems that you have picked up in respect of healthcare in the private and independent sector. Obviously we do see a distinction between the private and the independent sector.

4 March 1999]

MS CLARA MACKAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

[Chairman Cont]

(*Ms MacKay*) I will start on this one. In relation to private healthcare services, Consumers' Association has probably undertaken more investigations than any other consumer organisation. This work has been largely led through the work of our two key consumer publications, *Health Which?* and *Which*.

120. Could I ask you why you have done so much work on this area? You have done a lot of work obviously in this area?

(*Ms MacKay*) Yes, we have.

121. What motivated your organisation to spend so much time and money on this area?

(*Ms MacKay*) I would not say it is disproportionate to other health issues but I think, going back over a number of years in our initial work on private healthcare services, again almost specifically clinics, we had very early on highlighted some deficiencies that we felt were concerning enough to broaden the scope of that work and go back and retesting and revisiting. Over time that has built up to a considerable basis of evidence for this work.

(*Ms Williams*) Could I just add that it is a rapidly growing market. There are so many new services coming about now. We are trying to keep up to date so that the consumer can keep up to date with new GP walk-in clinics, for instance, slimming clinics, laser surgery. There are all sorts of areas of healthcare that are moving into the private domain and as that happens we are trying to seek it out and find out if it is a good thing and give consumers advice.

122. Why is it in your opinion such a rapidly growing area?

(*Ms Williams*) It offers some of the consumer principles in terms of access and choice. If you can pay, if you can afford to pay, then there are some things about private healthcare that are very good indeed, it is responsive, it can provide care at a time when you need it most. We need to make sure that there are not disadvantages with that.

(*Ms MacKay*) I think also we would say there is certainly a growing body of healthcare services that are drifting in from the public sector to the private sector. I think dentistry would be a prime example of that. It is becoming increasingly important. Dentistry, and I would add long stay care and private nursing care. It is increasingly becoming a wider consumer issue and not just about people with money who feel they can go down to a high street and buy healthcare off the shelf.

123. Sorry, I stopped you.

(*Ms MacKay*) That is okay. Before I proceed, it probably is important in a way to briefly outline the nature of the work that we have done and the scope of that work and perhaps not necessarily limitations but it is important you understand the context of our work. Our research has largely centred on private clinics rather than, for example, private hospitals or privately contracted nursing services. We have looked at private laser surgery, private slimming clinics, cosmetic surgery clinics and GP walk-in clinics and we have provided the Committee with that evidence in our written submissions.

124. Can I interrupt again. The reason you have concentrated on this, does that indicate that you have received more representations about those areas than the hospital sector?

(*Ms MacKay*) No, I do not think that would be fair to say.

125. Why have you concentrated on that area?

(*Ms MacKay*) We have concentrated on that area again—going back to my original point—when we dipped into it initially we did flag up quite key issues. With private hospitals, for example, it is quite a bit more difficult to conduct the type of research that we have conducted on the clinic.

126. You had actors and actresses going in.

(*Ms MacKay*) We have undercover researchers going in who are wired up, carry undercover recording equipment, that type of research is more conducive to a clinic situation rather than a hospital situation. In all of our work we feel that the issues we have raised are quite relevant and applicable across and we feel confident we can extend our conclusions and our concerns beyond the clinic setting.

127. Yes.

(*Ms MacKay*) I think probably, leading on from that, it is worth highlighting again that our reports are based on the outcome of these undercover investigations which we have done which do involve sending researchers out to experience services exactly the way that ordinary consumers would do. Also I think it is worth emphasising that when we have evaluated the results of that work, where appropriate, we have drawn in expert panels of doctors and pharmacologists to give them measures and criteria to evaluate the clinical exchange so that it is not just the people at the Consumers' Association making random observations about the clinical adequacy of care. I think just as a note I would like to point out also that the services that we have looked at are those that are largely ones that people would pay for out of pocket so that we do not have a great deal of research into the private healthcare sector where there is an insurance company or coverage involved.

128. Do you think that makes a difference?

(*Ms MacKay*) I do not know, to be completely honest. I do know there would be perhaps issues about redress through an insurance coverage scheme that may not apply to the individual contract relationship that you would have in a clinic setting but I cannot comment on it.

129. I wonder if there is any anecdotal evidence that you have picked up in your organisation that if one of the major insurers was paying for an intervention then there were checks by that company on the quality of care, the clinical quality of treatment being offered to people they were paying for?

(*Ms MacKay*) No, we have not, not to my knowledge. I do know certainly anecdotally there are issues about private insurance companies having designated providers but, again, that is not something that I can comment on and I cannot comment whether or not those providers have been identified because of the standard of clinical care. I think it is an issue which certainly I would hope the Committee would consider. I guess, to answer your question about the problems that we have identified,

4 March 1999]

MS CLARA MACKAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

[Chairman Cont]

if I could briefly summarise our main key points, and I am sure we will revisit these throughout our evidence, the Consumers' Association does not believe that the 1984 Registered Nursing Homes Act and supporting guidelines offer adequate consumer safeguards. We believe that the Act is outdated in that it does not provide enough scope with regard to procedures and services performed in private healthcare settings which should be covered. For example, we believe that GP walk-in clinics should be covered by regulations which they currently are not now. Also we have found in our research that the application of the Act can vary from one area to the next depending on the interpretation that a health authority might apply to the Act. For example, our researchers have found that some health authorities require clinics which perform collagen replacement therapy to register while other health authorities do not. We believe also that the Act is deficient in most cases where there is even widespread agreement that services should be covered by the Act, for example cosmetic surgery. Cosmetic surgery clinics are required to register under the Act but that registration does not give the patient any guarantee that the clinic will have appropriate resuscitation equipment or staff skilled in resuscitation skills on hand.

Audrey Wise

130. Do you think the fact they can be registered, and yet such important things are excluded, can produce a situation for the patient which is worse than if they were not registered?

(Ms MacKay) Yes, we do.

131. It can give a false sense.

(Ms MacKay) We do. In many of our reports one of our conclusions has been that we see registration of greater benefit to the provider as a promotional tool than it is to the patient as a guarantee of quality. We feel that is a very, very important issue, that there may be some false sense of security that the patient will have as a result of seeing a sign which says that the clinic is registered with a health authority. It does not guarantee that the staff that are performing the procedures have the appropriate skills, training or qualifications to be doing those procedures. Moving on from the specific deficiencies of the Act, CA has concerns on behalf of those who use private healthcare services in relation to the lack of formal redress, both in terms of in-house complaints policy and also in terms of access to an ombudsman scheme which is something that is a common standard in many other industries including banking, insurance and legal services. We are very concerned about the lack of clarity which can exist between what is the patient clinical consultation and what is the sales promotion of consultation within a clinic. For example, we have found instances where staff responsible for a preliminary assessment and perhaps a physical examination were not clinically qualified.

Chairman

132. What qualifications would they have had?

(Ms MacKay) Sally may have more background information. They would be front line staff, people who are working in the office or in a clinic as an assistant.

133. You mentioned in your evidence, as I recall, that a person will be seen by a consultant.

(Ms MacKay) Yes.

134. The term "consultant" implies something to me different from what you are picking up.

(Ms MacKay) Precisely.

(Ms Williams) We have explored cosmetic surgery in consultations. We have asked "Are you a medical consultant" and they have said "No, I have no medical training". They do not even have a first aid certificate. What they are is a sales consultant. Not only are they giving advice about treatments and benefits, they seem to be very keen to want to play down the risks because they are so desperate to make a sale but also they are doing physical examinations which is something we have enormous concern about.

135. You are saying that people who are effectively lay people, sales people, are conducting physical examinations on patients?

(Ms Williams) Yes.

136. Does that not raise quite serious questions of legal assault perhaps?

(Ms Williams) The guidelines that currently exist—

Chairman: Peter, do you want to come in on this?

Dr Brand: I can help you on that.

Chairman: Yes.

Dr Brand: No-one is allowed to physically assault an animal, because an animal cannot give consent, except a vet. Anyone can assault—it would not be an assault if it is with consent—clearly it depends on what you pretend you are. If you are not pretending you are medically qualified and it is a therapeutic assault, with consent, that is all right. If it is a non-therapeutic assault, even if there is consent, it would not be all right. I think that is about right.

Chairman

137. Can I come in on this. Obviously the law is clear in respect of people pretending to be doctors. It is illegal to do that.

(Ms Williams) Yes. I cannot pretend to be a doctor but I can call myself a cosmetic surgeon. I could go to Harley Street and I could rent a room—

138. And you could call yourself a consultant.

(Ms Williams) I could call myself a consultant.

139. I would see you as a consultant as I would see a consultant in the NHS. The first outpatient appointment normally you would see a consultant probably but the consultant I would see in some of these clinics would be a sales man or woman?

(Ms Williams) Not always but in many of the instances.

140. Could be.

(Ms Williams) Yes.

Audrey Wise

141. Are you saying that you cannot call yourself a doctor but you can call yourself a surgeon?

(Ms Williams) The term "doctor" is legally defined so it is illegal to call yourself a doctor if you are not registered with the General Medical Council and qualified as a doctor. Anybody can call themselves a

4 March 1999]

MS CLARA MACKAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

[Audrey Wise Cont]

cosmetic surgeon, put a plaque on the door and open their clinic up for consultations, doing examinations and giving treatment.

142. So the term "surgeon" is not a protected term at all?

(*Ms Williams*) You can have the initials "FRCS" after your name which means you are a Fellow of the Royal College of Surgeons.

143. Yes.

(*Ms Williams*) They have checks in place to make sure only doctors will have those initials there. There are problems with people who are in a vulnerable situation, particularly if they are going for things like cosmetic surgery, going to a clinic, seeing somebody about their qualifications and expertise.

144. You are really telling me that the term "surgeon", is not protected?

(*Ms Williams*) As far as I understand it.

145. If you can call yourself a cosmetic surgeon, it does not seem to me that the word "cosmetic" really qualifies the word "surgeon". You could not call yourself a cosmetic doctor if you wanted to.

(*Ms Williams*) I think part of the problem is that there are no minimum levels of training for cosmetic surgeons. You do not have to have done so many procedures before you can call yourself a cosmetic surgeon. An ENT surgeon may move into cosmetic surgery or it may be people who have had some experience of cosmetic surgery in the NHS, although there is very little cosmetic surgery happening in the NHS. One of the problems is that there is not a particular qualification, a minimum standard.

Chairman

146. Could I just come back on this point, I will bring you in, Ms Meredith. You mention a surgeon could be a Fellow of the Royal College and therefore is clearly accepted as a surgeon with the skills and qualifications implied but you do say in your evidence, unless I have misunderstood it—I am quoting from page six—"There are also two professional associations—the British Association of Aesthetic Plastic Surgeons and British Association of Cosmetic Surgeons, but membership is voluntary and does not necessarily indicate that that practitioner has specific training and skills relevant to the area they are working in."

(*Ms MacKay*) That is correct.

147. Somebody could be a member of these bodies, with all that implies, along the lines of the Fellow of the Royal College of Surgeons?

(*Ms MacKay*) Yes.

148. But yet not have the qualifications that would be assumed by a lay person, such as myself, who sees it on their plaque?

(*Ms MacKay*) That is correct. You could be a member of these organisations. You could have experience and skills and training to enable you to be a member, yet you could be operating or doing procedures that are quite specific and perhaps the skills that title gives you are not relevant to that particular procedure.

Mr Walter

149. Let us be absolutely clear on this. Are you saying that somebody could be a member of either of these organisations and not be medically qualified?

(*Ms MacKay*) No.

150. Or are you saying they could be, let us say, a specialist registrar in general surgery but then join this organisation and go and practise as a consultant in cosmetic surgery in the private sector?

(*Ms MacKay*) Yes, I think that would be accurate.

Dr Brand

151. Chairman, it would be helpful if we wrote to those organisations and got a definition from them.

(*Ms MacKay*) I think that would be very helpful.

152. I think the point you are trying to make is that you can be an experienced cosmetic surgeon dealing with ears and it does not stop you doing breast jobs.

(*Ms MacKay*) Correct.

153. I think you are drawing it too wide as to say that you can be totally unqualified as a surgeon and belong to—Certainly one of those organisations is an extremely respectable one.

(*Ms MacKay*) Yes. We are not suggesting that.

Chairman: The distinction was made that a person can claim to be a surgeon who is not.

Dr Brand: I think that would be fraud.

Chairman

154. What is your opinion on that point? It is a very important point. I got the impression you were saying that claiming to be a doctor and not being one was illegal. What about the position of someone claims to be a surgeon?

(*Ms Williams*) Our understanding is that anybody could claim to be a cosmetic surgeon and open for business.

155. Anybody could?

(*Ms Williams*) If they started using anaesthetics and doing operations, I am not clear about what would happen then. Certainly they could carry out consultations on patients and do examinations.

Audrey Wise

156. The advice I am being given is that you cannot hold yourself out as being a surgeon unless you are medically qualified. You have to be a doctor and providing you are a doctor you can call yourself anything consequential on that.

(*Ms Williams*) Yes.

Dr Brand: Chairman, I have got a surgical qualification, I would not call myself a surgeon by any means.

Audrey Wise: It would be illegal if you did.

Chairman

157. We need to look at this. This is a very important area in terms of our inquiry.

(*Ms MacKay*) I think it is an extremely important area.

4 March 1999]

MS CLARA MAC KAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

[Chairman Cont]

158. It is a complex area but so important we need to clarify this and perhaps we can come back to this. Ms Meredith, you wanted to come in on the general point?

(Ms Meredith) Very briefly, Chairman, thank you. It is simply that if we get too hung up on surgeons we miss a huge amount of private healthcare where this issue arises, partly because titles are not protected through the professional self-regulation and partly because not all professions that practise healthcare have statutory regulations or indeed some do not have very much regulation at all. The National Consumer Council, as you know, is quite a generalist organisation but one of the things we have been working on over the past few months, and actually have a report in draft at the moment, is on this whole question of professional self-regulation which of course is topical because of the Health Bill and the new powers that will be created through that. I think it is very important, it is clearly important, that when surgical interventions are being made the consequences, of course, could be very grave if things go wrong. Consequences can be very grave in other areas when things go wrong, when anybody can set up as something like a counsellor or a psychotherapist or a psychologist for instance, some of which have voluntary schemes but which do not have protection of title. I just wanted to make that point here because you are looking at independent healthcare and it is very much wider than just hospitals or surgical interventions.

159. From your perspective do you have any further points on the first question I asked about the problems you have encountered within the private sector which have not been covered already?

(Ms Meredith) I think we would simply suggest again that it is difficult if you try to just look at institutions or professionals or the way the service is provided. From our perspective at the National Consumer Council, how we come at quite a number of these issues is by trying to look at what happens to the people using the services. Their journey in and out of the services or the place is actually often as important as what happens to them in the place. It is very important to keep that in mind: how are you referred, what kind of information you have before you go in, what kind of support do you have after you come out, and I know these are issues which the Consumers' Association also raises. In that respect I think it is very important to bear in mind the interface of the independent healthcare sector with both the NHS and with people's own private lives as they move in and out. People have different routes of access into private healthcare. It is crucially important to focus on what happens to the individuals because so many of the people using independent sector healthcare are behind closed doors in their own homes or in a private consulting room over a health food shop seeing the psychotherapist or an acupuncturist or something like that. Those areas are places where people can be even more vulnerable than if they are going to some place which is an identified institution and which may have other means of protection in place.

160. Ms Johnstone, do you want to add anything so far?

(Ms Johnstone) No, I think Barbara has covered the main thrust of our opening.

(Ms MacKay) Could I add one last point because I think it is relevant to everything we have just discussed—very relevant—which is the concern about the consumer access to information. We feel that particularly within the private healthcare sector much of the information that is available and provided is advertising and promotional information. Consumers are at a great disadvantage if they actually do wish to pursue some questions or to get more information about the services that they are offering. We see there is a big deficiency in that area.

161. Can I ask, do you have any hard evidence of the numbers of patients who may have suffered from poor practice in the private sector? I seemed to spot some figures somewhere which were quite high of the number of people who made complaints. I am not sure which section of evidence it was in.

(Ms MacKay) I do not think it was our's.

162. Do you have any hard evidence, any stats, that would be of help to the Committee?

(Ms MacKay) No, not in terms of people who have actually made complaints. In our evidence we have tried to give some indication but it is very difficult to pin down the numbers involved of people who might be accessing private healthcare. Again this relates to a very important issue which is that although many private healthcare services would have informal or formal but not regulatory complaints procedures, there is no monitoring of the complaints which are being made.

163. It is very difficult to establish.

(Ms MacKay) It is impossible at this point, yes.

164. Before I pass on to my colleagues, could I ask one final point. Ms MacKay in opening up you made reference to why people use the private sector, what they perceive to be the advantages of using the private sector. Do either of your organisations have examples of good practice arising in the private sector which we ought to be aware of?

(Ms Williams) I think one thing to make clear is we do not set out to expose poor practice. We are not on a witch hunt and we try and make our reports balanced and fair. Not all consultations, not all visits, not all contact with services are bad but we have found that we seem to stumble across acceptable practice rather than there is a framework set up to nurture it and make sure good practice is there. We would say that on the whole, no, we have not and if we have it is an accident.

165. You have not come across any examples?

(Ms Williams) No. When we have done consultations with cosmetic surgeons or with private GPs or with slimming clinics we have found that not all consultations are as bad as each other but I think that is probably the best we can say.

(Ms Meredith) I think in a more general sense one does need to recognise the work that various trade bodies do in trying to set high standards for their members. For instance, at the moment, the Independent Healthcare Association is consulting on the complaints procedure. To that extent, the extent to which organisations or providers belong to trade organisations, there may be ways in which practices are monitored according at least to some self-set

4 March 1999]

Ms CLARA MACKAY, Ms SALLY WILLIAMS,
Ms JILL JOHNSTONE AND Ms BARBARA MEREDITH

[Continued]

[Chairman Cont]

standards, I think there are some major concerns about the very wide number of individuals, if not group providers, that are not members of such bodies so that is a major issue. I think the second thing, going back to your question about do we know about the number of complaints and things, one of the major issues is accountability of all kinds of services, transparency and openness in how do they publish, how do they monitor and evaluate, what do they publish, how can people find out about performance and what has gone on. I think particularly in the independent sector there may be issues, which maybe we will come on to later, about things like litigation and things, having published information about complaints and the extent to which problems arise or adverse incidents. It is a real problem how we get access to that information whereas the NHS is starting to move to better recording and better publishing of that kind of information although there is probably a long way to go there as well. The issues of openness and transparency are very important. One of the reasons we cannot respond to your question is there is not any way of knowing.

166. We understand that. It is a very important point in terms of our inquiry.

(Ms Meredith) Yes, I am sure.

Mr Lewis

167. I think this is probably a question to Ms Meredith. What do you feel the principles should be which actually underpin the regulation of the independent sector of healthcare? Do you think there should be any significant difference in those principles with regard to the public sector?

(Ms Meredith) Perhaps the first thing to say in answer to that is that the principles should probably be the same across the board. The principles are about people, about safety, quality, access, representation and redress and the availability of complaints. I do not see any reason why principles of regulation should be different. I think there are two issues around whether the application of the principles or the pursuit of achievement of goals might be different because of the different nature of the NHS and the private sector. For instance, in the NHS we do not really look at how the market is regulated particularly, it is a particular kind of market and it needs to have checks and balances. As we have already heard, in the independent sector people are paying in different ways and that may raise questions about what kind of regulation there is around the prices or access or again people's information about what they are getting. There is an overarching issue about the regulation of professions which we have already touched on and there are questions about inspection and registration and the extent to which there are sanctions which can be applied if things go wrong. It may be worth looking at the differences between the sectors, even things like the difference in employment practices between the sectors, to see whether you can apply just the same thing as a job lot across the board or whether you have got to be picking out certain ways in which the two sectors might have to be different. From people's point of view one of the major things that is happening at the moments in ways which even they often do not fully understand. Our Consumer

Concerns report last year, which was a broad survey of some people's different attitudes towards healthcare, showed that for instance in using dentistry a certain number of people were uncertain as to whether they were having private or NHS dentistry and they were uncertain about how much they would have to pay. There are some very important questions to be asked about protecting consumers' interests when they think they are using the NHS or when they are slipping between the NHS and the private sector. And that of course is not even simple because sometimes they may be using the private sector under contract to the NHS so they ought then to be protected by the NHS. I think those are some of the broad issues that we would raise. Primarily the questions of safety and representation and redress are things which need to be looked at, how they are applied in practice in different areas. As I have already said, obtaining information can be difficult. There are questions about how people get information, for instance, in a one to one consultation. That is not unique to the private sector, in the public sector as well people are intimidated when they are with a professional from asking "Well, tell me, doctor, how have you done in this in the past six months" when maybe they have just been told something about the average risk of a particular treatment or intervention. Just one final point. I think there is a major issue about consent to treatment. We have had discussion already about the way people may be examined. There is a fundamental underpinning point that people have a right to give consent before any medical intervention or treatment and the extent to which that is applied, the extent to which they are told that—

Chairman

168. Do you mean informed consent or just consent?

(Ms Meredith) No, informed consent. A Health Service circular just came out last week clarifying this which the Committee might want to check up on because it makes very clear that this has to be informed consent about alternatives and options and the possible risks. I think at this table we would argue that these risks ought to be not just general risks but specific risks about the particular place that you are in and the person who is doing the treatment or of the medicines or other kinds of things you are being offered.

Mr Lewis

169. Perhaps I could ask Ms MacKay to answer a similar question on the relationship between the public and the independent sector.

(Ms MacKay) Yes. I will not just cover the same points that Barbara has made but I would like to say that we support all of them. I would just add two things, maybe specifically on the issue of the difference between the public and the private sector, different perspectives about regulations. Certainly within our research what we feel comes through very strongly is that there is a tension between the needs or the desire to provide good quality care and the financial objective of making a profit. We feel that does introduce something quite unique to private

4 March 1999]

MS CLARA MACKAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

[Mr Lewis Cont]

sector healthcare. I think we would point out, or we feel quite strongly, that within the public healthcare sector there are numerous checks and balances which are just inherent in that system. Some of them are legislative checks and balances and some of them are through direction and guidance. For example, a chief executive of an NHS trust has statutory responsibility for the quality of care provided within that institution and that is quite unique to that. Health authorities have responsibility for quality measures, monitoring, prescribing practices, etc.. We feel that there is a need to perhaps level the ground but perhaps the approaches need to be slightly different taking into account the different cultures and different inherent issues within the sector.

170. I accept the point that the approaches may need to be different and the structures need to be different. Do you think the principles should be different?

(Ms MacKay) I think the principles are absolutely the same as what Barbara has outlined, absolutely.

171. You would say the principles in the public and independent sector underpinning regulation ought to be the same? Do you think there is any justification for having different principles guiding it?

(Ms MacKay) Perhaps Barbara would like to expand on that, aside from the two points I have made but taking those things into account. I think from a patient or a consumer perspective the principles remain the same about access, right to redress, quality and safety.

(Ms Meredith) Can I briefly come back on that? I do not know whether I mentioned the importance of independent evaluation and monitoring. I do believe it is difficult for me to just envisage what different principles there could be, if you are thinking about people using healthcare services. I find that trying to think how there could be any differences when you are talking about people using healthcare and wanting to ensure safety and good outcomes, is difficult to understand. There is an issue always, in all forms of regulation, whether publicly done and statutorily done or whether self-regulation, about how they might be independently evaluated and monitored. In healthcare there is a particular issue about the extent to which patients themselves are involved in setting standards and evaluating and monitoring outcomes. This again is an issue in the National Health Service but I suggest it also could be a major issue in the independent sector because so often outcomes are defined in clinical terms, you know: "Did your blood pressure go down" or "Did you die or not?". Even dying is not always the most important outcome. There is evidence to show that people would make trade-offs and decide whether or not to have a treatment even though they might die sooner. I think it is very important in any system when you are monitoring and trying to assess quality and outcomes that you show how you have taken account of the views of people who have used the service.

Dr Brand

172. Can I assume that none of you think that the 1984 Act is a satisfactory framework on which to underpin the regulation?

(Ms MacKay) I think that is a fair assumption.

173. I had a Parliamentary Question of the Minister of Public Health because I have been very concerned about the regulation of this. She implied that the answer was in better regulation of the clinicians and that if the General Medical Council was more responsive and if we had better regulation of the other clinical services that would deal with the problem. I would like some feedback from you whether in your experience most contracts for treatment are between patients and the clinicians or whether they are between patients and the organisations which employ the clinicians and, depending on the answer to that, is that a bar on reasonable complaints and regulation? It is a complex question.

(Ms Williams) There are lots of different things in that but I will try and get to them all. We have had quite a lot of experience of making complaints about doctors in the private sector to the General Medical Council. I think all of our complaints so far have been rejected partly because they are not about real people,¹ they are about researchers presenting themselves as patients, but also because they have crossed that line between whether it is a problem with a doctor and whether it is a problem with a clinic. We feel very much that a doctor who is in a clinic, say a cosmetic surgery clinic as we keep coming back to that, have to take some responsibility for the environment in which the patient is seen: the standards, the cleanliness and the quality of care and also taking responsibility for the fact that that patient may have been given advice by a sales consultant, somebody who is not medically trained. In that regard we would like to see the General Medical Council, as a body which deals with complaints about doctors, take that on board. They have been very clear, they will only look at a doctor's performance.

174. Do you think the answer lies in making the General Medical Council more flexible in the way it acts or should the regulation of the employing authority be more strict? I have complained to, say, a slimming clinic about the standards of poor clinical practice within their establishment and the response I have had from the management of the clinic says: "You are complaining about an individual clinical decision by this independent doctor and it is nothing to do with us". This way both sides use the absence of regulation to absolve each other.

(Ms Williams) Certainly we would like to see the clinics take much more responsibility for what happens and the care they provide. As Clara was just saying, chief executives in the NHS now take personal responsibility and are accountable for the clinical care that is provided in a trust and we think the same principles should apply to the private sector. At the same time I do think that the GMC could extend their role and do more to protect patients in this area which would involve setting out guidance for doctors on best practice in private practice and also reinforcing the importance of reliable, clear information and making a distinction between clinical activity and sales activity.

¹ Note by witness: This is our impression. In reviewing our correspondence with the GMC we realise that they have never stated this.

4 March 1999]

MS CLARA MACKAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

Chairman

175. Peter, could I just come back on one point which I have picked up from your question. Did I get the impression correctly, Ms Williams, you were saying that the GMC refused to act upon complaints put forward by your organisation on the basis that the complaint was based on an actor or actress or somebody who was not a real patient?

(Ms Williams) No.

176. Can you repeat the point you made? You said they were not prepared to pick up complaints that you had put forward.

(Ms Williams) No. They looked at our complaints. None of them was upheld.

177. They examined the complaints?

(Ms Williams) Yes, they looked at them. None of them was upheld. The reasons around that included that it was very difficult because it was not a real consultation with a real person but also they were very keen to point out to us that many of our complaints were concerns with the issues around the clinic, not just the doctor's performance. They were very clear to emphasise that they will only look at a doctor's performance and none of the wider issues.

Dr Brand

178. Can I ask what the National Consumer Council view is?

(Ms Johnstone) I think you have picked on a very important point. In our evidence we were trying to point out that professional self-regulation is only part of the story, that is regulating people. What about the services and the institutions in which they are taking place, there needs to be regulation there. There is a separate regulation of products and medicine. There may be marketing issues about comparative information about prices so people can make informed choices. It cannot all be done through professional self-regulation, although obviously we would like to see improvements there. It is only part of the whole problem.

179. What sort of model would you want to see in that? In my experience it is actually quite difficult to register a nursing home, you need to be a fit person to be owning it, a fit person to be in charge of it and you have to have staff up to a certain standard whereas the inspections of cosmetic surgery clinics from what you are telling us seem to be extraordinarily inconsistent, I think is probably the best word.

(Ms Meredith) Again this is partly a question of evidence and breaking down the task to try to be clear. There is something about fitness for purpose in all this. The trouble with talking about the independent healthcare sector is that it is not just one thing.

Chairman

180. We understand that.

(Ms Meredith) Talking this way in a very general sense makes it very difficult to come up with a model. I think the point about professional self-regulation is that it is trying to ensure that people who practise with a certain title—and there are issues around the use of titles—are safe to practise, have been educated to certain standards which are set by the profession

and have ways of monitoring and reviewing their performance which are currently being strengthened. It is not only doctors, it certainly is nurses and certainly it is professions allied to medicine and other people who need looking at in this respect. All that needs to be strengthened. The contract for some people will be with the individual. Because of the consulting room over the shop, there is not a clinic or something, it is the person who has hired the room.

181. But there is clear accountability because it is a contract with that one person?

(Ms Meredith) That is absolutely right. When the person is practising, again somebody talked somewhere along the line about people being employed, the employment situation of the different practitioners both in the NHS and outside the NHS is very complicated. Some of them are employed by the institutions, some of them are guests in the institution using the facilities. That needs to be sorted out to get the contractual thing clearer because I suspect there are issues which certainly we have not looked at in any detail at all about the nature of this relationship depending on where you are.

Julia Drown

182. I would like to turn to the cost of regulation. We have heard in previous evidence sessions how insofar as there is regulation at the moment there are fees charged for private hospitals and nursing homes registering with the health authority but those fees only cover about half the cost of regulation. In your view who should cover the cost of regulation? I suppose that is relevant not only to now but, as you are making clear, if there was increased regulation who should pay the price of that?

(Ms MacKay) I think the question of who should pay for regulation is always difficult. As a general rule the Consumers' Association accepts that regulation does carry a cost some of which, if not all, should be borne by consumers. Our test is that we feel consumers are willing to accept this but only if the cost is proportionate to the benefits gained in terms of health, safety, fair trading practices and better information. Inevitably the cost of regulation of private healthcare will be passed on to the consumers through registration, as it is now. I think I would like to point out briefly also that we would never promote regulation for the sake of regulation and we are very cautious about when we would see the need for intervention. Some of the factors that we try and think about are issues about risk and complexity of product and the fact if the consumer needs some sort of framework to support their safety and their health and their ability to access a good product then so be it. I think we would point out also that there is a number of savings I suppose from tidying up poor regulations which need to be taken into account. Regulations should not be unnecessarily burdensome or emphasising on the administration rather than the outcome and that needs to be taken into account. Also the costs that can be saved from better regulation which means people are not returning to use health services because of the first consultation or experience was of poor quality and also the human cost. Those are important things.

4 March 1999]

MS CLARA MACKAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

[Julia Drown Cont]

183. Do you think the current practice whereby the public sector subsidises the cost of regulating the private sector is wrong?

(*Ms MacKay*) Personally I have no evidence that is the case. I understand that was in a submission to you so I cannot comment on that fact. Certainly I feel it is something which needs to be looked at and certainly it is an issue and needs to be dealt with.

(*Ms Johnstone*) I would just like to support everything my colleague has said. We have accepted in other sectors that the cost of regulation is borne by the industry and then passed on to its users: food is an example, utilities, financial services are other ones. We have no difficulty in that context. If there are cross-subsidies going on, which we do not have evidence about, they certainly ought to be looked at.

184. Can I just ask about consumers' rights in all of this. I think you have made it clear that people are not aware enough of their rights when they are using the private sector. How would you want to see that improved?

(*Ms Meredith*) It is an interesting issue, the question of rights. We have talked already about people's right to give consent to treatment which I think is very important. In general we would say people have a right to information and to a contract and to understand what the terms of the engagement are. One thing that we would like to draw out here is the extent to which rights, particularly possibly in the private sector, are maybe diluted because of fears of litigation and expensive things that might arise when things go wrong so people close ranks and communication is not as good as it ought to be.

Chairman

185. Why do you draw a distinction between the private sector and the NHS in that respect? With the evidence we have had from the NHS you could argue the same line.

(*Ms Meredith*) Yes, absolutely. Shall I go on?

186. Yes.

(*Ms Meredith*) I was just going to go on to say that in all such instances the National Consumer Council has been very supportive of the new Pre-Action Protocol for the resolution of clinical disputes which is going to be coming in at the end of April. We think this is going to be very important and it may need to be looked at as to how it is applied both in the NHS and in the independent sector to prevent people having to go down the route to unnecessary litigation simply to find out what has gone wrong and why, and to try to sort things out in the intermediate stage. Work that we have done in the past has shown that one of the major reasons people go to litigation in medical disputes is simply to find out what happened because they could not find it out, and to prevent things going wrong for someone else in the future. They do not want to be in court, many do not; clearly there are some cases which need to be in court but a lot of people do not want to be there. In terms of rights, it opens up a whole area of communication and exchange of information. If you start to look at what is going to have to be put in place for this Pre-Action Protocol, it is going to be things like reporting adverse incidents and other information which will help people to not have to go too far down the very expensive and undesirable road for many, if it can be

prevented with better systems earlier on. I would just like to raise that in this context because I think in private sector care rights are often seen as either you go to the relevant professional body or you have to go to litigation. Certainly we want to promote the idea that there should be somewhere before you get fully down the road to litigation.

Julia Drown

187. It is all about rights though when something is going wrong, what about the rights of somebody who is walking into that clinic for the first time?

(*Ms Meredith*) I think we have already all implied that we believe people should have information about the nature of the transaction or the exchange. There is a major issue in referral I think between the NHS and the independent sector. People often access independent sector services through either the National Health Service through their general practitioner, or through a consultant saying: "I can do this quicker for you tomorrow if you come to me privately", or through local authorities who are placing people in nursing homes. I think that there is a major issue about the kind of information that maybe people ought to be able to expect in having that situation presented to them. We know in long-term care that people do not get adequate information about the possible cost to them before they are heading down the road of using private sector care. There are major issues there.

188. You would like that in that first contact, be it long term care or a walk-in clinic, this sort of information to be provided and these are the sort of questions people should be asking?

(*Ms Meredith*) Yes.

(*Ms Williams*) Can I just add something? In terms of basic rights, the patient should have a right to quality services, basically to access to an adequate redress system, to appropriately trained and experienced staff. Also the Government set up an Independent Review Group which published a report last July and they were looking at the safety of silicone breast implants and one of the things they did do was look at the whole idea of a woman going to a clinic, particularly in the private sector, which is where they are most likely to be getting implants. They made a number of recommendations which we think are really important in this area and should be applied across the board to other areas of private practice. They recommended that there should be an initial appointment with the surgeon who is going to carry out the operation, that you should always have that, you are not seeing salesmen for instance. They recommended a cooling off period between consultation with the surgeon and when you have an operation. They recommended that the patient should be assured that they will never come into direct contact with somebody selling a service—selling an implant, in this case, with the manufacturer—until they have had time to think about the operation and the procedure and make a decision about it. There are more recommendations that you may want to look to in that area.

4 March 1999]

Ms CLARA MACKay, Ms SALLY WILLIAMS,
Ms JILL JOHNSTONE AND Ms BARBARA MEREDITH

[Continued

Mr Gunnell

189. Just one question I would like to ask which relates to the cost of regulation of private care. This follows evidence which we heard at an earlier session. We know that when people leave private care if things have gone wrong in their treatment they often go into the NHS and the NHS have the cost of repairing the damage which has come from the private sector. In those circumstances where you can identify individual insurers who insure that patient for the treatment in the private sector, would you think it was reasonable that the Department of Health should reclaim the costs of the work they do against that private insurer because that would be a way of offsetting the costs of regulation?

(*Ms MacKay*) It seems very reasonable that would be something to look at. Again I do not have a great deal of perhaps knowledge and enough insight to comment specifically on that, but I think the Consumers' Association would say that certainly this whole issue about cross-subsidising is something that is important and needs to be looked at and taken into account. Certainly it seems reasonable that an insurance company that has taken responsibility for an initial purchase of care should have, if not legally, morally some responsibility for the follow through and the consequences of that care.

Chairman

190. Do you think that it might improve the checks that are made on where the care is being carried out and the clinical capacity of the person concerned to carry it out if this kind of system that John Gunnell is suggesting comes about?

(*Ms MacKay*) I think I could see it driving a quality agenda and greater attention and greater sense of responsibility for the whole path of that care, yes.

Mr Gunnell

191. We were aware of the fact that the Department of Health had not come to a decision as to whether they would follow that line through and it seemed to us very reasonable or some of us very reasonable that they do so and they should attempt to recover the costs.

(*Ms MacKay*) Also I think there is an important point related to that, not necessarily about the finance but the planning of care, that in the instances that you are alluding to where something goes wrong in a private setting and the person needs to move into the health service for support, that is not planned within that overall health service planning for provision of care, it is something that is dropped in. Certainly I have heard anecdotal evidence that makes it extremely difficult, particularly for the very high level care, intensive care procedures and those kinds of services which can make it extremely difficult to juggle those demands and to make decisions about how to juggle them.

(*Ms Williams*) Could I add something which is related to this but it is drawing it a bit wider and that is the impact of private practice on the NHS and the relationship between the two in the wider context. We have done quite a lot of work looking at NHS consultants and how their private practice could

possibly interfere with their NHS work and have an impact on waiting lists. This is something that the Audit Commission have looked at also. Three years ago they found that the 25 per cent of consultants that were doing the most private work were doing less NHS work than their colleagues. We would invite the Health Select Committee at some point to look at the wider impact of private practice on the NHS.

Chairman: As far as I am concerned you are pushing at an open door.

Mr Gunnell

192. Could I just say since the Consumers' Association are here, in fact the Consumers' Association had an influence on the way we set out on this inquiry because, I do not think it is a matter of declaring an interest, a number of us take Health Which? and had access to the walk-in clinic report at the time we were considering the immediate future programme. It was very clear it was an area where regulation was needed.

(*Ms Meredith*) Could I make one short point, it is to do with insurance and picking up afterwards. It is a question of the nature of the product itself, the insurance product. It is not only when things go wrong, actually it is often you have the acute treatment in a private hospital paid for by insurance but, for instance, rehabilitation is not always covered by the insurance scheme. Rather than having to go afterwards, retrospectively, to sue for the costs, is there an issue about what the products are in the first place and the extent to which consumers are sure they are getting a product and service which will cover their full needs if they need to use it and call on it.

Audrey Wise

193. Conflict of interest is a quite difficult complicated concept, I think, because possibly in many instances there is some kind of conflict of interest. It could be said even in the NHS there might be a reluctance to provide a procedure because of the conflict between managing the budget and giving optimum care. The idea of conflict of interest in private health care seems very obvious. The dual clinical and commercial functions make it quite difficult to be perhaps objective in advice giving and planning of treatment. Do you think that is at the heart of a lot of the problem, that it is not quite clear whether this is selling something, selling the product or providing the service?

(*Ms Williams*) Yes, we do think that is at the root of a lot of the problem. Going back to what we were saying before about this, there is a lack of clarity between what is a clinical consultation and what is actually a sales person trying to sell you a product, a service, and that is an area where we would like to see a lot more clarity and a lot more guidelines over what should happen and who patients should be given information by. I would not want to be given information if I was going to have an operation about the risks and benefits of it from somebody who did not know about it. I would not want to be given it by a sales person who I know is making commission by me having that operation. We do find in our experience that some consultations are

4 March 1999]

MS CLARA MAC KAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

[Audrey Wise Cont]

extremely sales orientated and unfortunately it is not just sales people that are putting pressure on patients to sign up for surgery, it is nurses as well as in some cases surgeons. Across the board there needs to be some distinction between what is clinical activity and what is not. We did find that the risks of surgery were very often played down which is something we are enormously concerned about, whether it is cosmetic surgery or slimming clinics' advice, it is all serious, it is all medical and the risks associated with this wide range of procedures, there is always some element of risk for the consumer, for the patient. Also we found that people were being persuaded to have unnecessary procedures or treatment. An example of this was that our researchers who were going into cosmetic surgery clinics were persuaded to buy a skin preparation solution which they were told they should have and keep using in the run up to surgery. We got this analysed and it was just an antiseptic, it was no more than that. Our experts advised us that it served no purpose. It cost £80 so the clinic clearly profited from that. There are other examples of where patients have been made to pay hefty deposits before they even see a surgeon, before they have the opportunity to discuss surgery, they are having to give money up front, there is no guarantee they will get this money back if they change their minds and it is unclear what would happen in those circumstances.

194. There is an implication there, is there not, that the outcome of the consultation will be that surgery goes ahead.

(Ms Williams) Predetermined, yes.

195. It is a sort of give away. I was interested in some of your earlier answers about your attempt to take up complaints with, for instance, the General Medical Council. It struck me—I wonder if you could say whether this is your opinion—that some of the things that are wrong may not be the kind of things very likely to engender individual complaints.

(Ms Williams) Absolutely.

196. If you have an operation and it goes wrong then clearly that will engender a complaint, you will want to make a complaint to somebody. To take some of the examples that you give about slimming clinics, for instance, giving out of drugs at half of the appointments which your researchers went to, clearly against the appropriate guidelines, and not informing GPs about the medication being given to the person as patient, they are things that are not likely to engender individual complaints.

(Ms Williams) We found this very frustrating because we have been complaining about the general advice. We could not say the doctor did something diabolical, it was not a clear case of assault or the doctor was not drunk as he was examining patients. It was more about the advice he was giving, it was not good, he may have been putting pressure on the person to sign up for surgery, he may have been playing down the risks, he may have been prescribing inappropriately but all those things we found quite hard to set down on paper and that is why we have had problems getting the GMC to take our complaints forward.

197. An individual patient would not be so conscious because they would only know their own consultation. You know a number of consultations

so you can build up a general picture. I would have thought that the appropriate authority, the GMC in particular, should have been extremely interested in that kind of scrutiny which after all can help to avoid individual need for complaint which may well involve some tragedy. I find what you say really disappointing.

(Ms Williams) I think part of the problem is that you do not know what to expect when you go into one of these clinics. Going back to what you were saying about good practice, there is not a structure of what should happen as a patient going for a cosmetic surgery consultation or going to a slimming clinic, what should I as a patient look out for? Consumer groups like ourselves are trying to set that out but it is very difficult for the average person who has picked up an advert in a magazine, say, and is following something and going to one of these clinics to know whether what they are getting is the real thing or very dangerous care.

(Ms Meredith) Very briefly, I think there are two things. I think that absolutely highlights the need for a consumer education exercise which is not necessarily the Committee's responsibility, to have people themselves feeling much more empowered in checking what it is that they are going in to get. I think a framework is needed for people to help them do that. Also, I think this discussion highlights the importance of a proper complaints' procedure because if you have a proper complaints procedure and you have a requirement for a proper complaints' procedure it can absorb different kinds of complaints, all sorts of different things can be complained about through a complaints procedure, which should be properly logged and recorded, and then they should be able to be used. The GMC does have an interest now in professional performance. They are able to look at doctors who are not doing serious professional misconduct but who over time are not performing up to scratch. You only uncover these things if you have systems whereby you can log over time, whether the same sorts of complaints are coming up over and over again. There is a key need for linking the complaints procedures, the regulation of the professions and the monitoring of the kinds of complaints which are being made, easier perhaps when you have an institution, much less easy when you are dealing with a one to one situation where there is no institution involved.

198. I would be interested in your supplying us with copies of the correspondence that you refer to here so we can see the way you expressed it to the General Medical Council and the way they responded. Another thing which occurs to me, which I would like your views on, is it is a very disparate sector, as Ms Meredith has said, but looking specifically at slimming and cosmetics, which have some obvious linkages, it strikes me that people going for those services may almost by definition have extra vulnerabilities.

(Ms Meredith) Yes.

Audrey Wise: Most of us feel sufficiently comfortable in our bodies not to want cosmetic surgeries unless we have had

Chairman: Speak for yourself Audrey!

4 March 1999]

Ms CLARA MacKAY, Ms SALLY WILLIAMS,
Ms JILL JOHNSTONE AND Ms BARBARA MEREDITH

[Continued]

[Audrey Wise Cont]

Audrey Wise: I will speak for myself. Certainly I think that. I would feel differently of course if I had a dreadful accident. In the normal course of the face lifts, the enlargements and the cutting downs and this sort of thing, it might be particularly difficult for those patients to complain even if the complaint procedures were good. If the complaints' procedures are really virtually non-existent and, for instance, the only thing you could do would be perhaps to make a big song and dance in the press or something then it seems to me there may be a lot of people suffering in silence because they feel a sort of shame that they have done it in the first place.

Dr Brand

199. Can I pick up on that, Chairman, because I think one of the problems is that a lot of people go to these private clinics because they have been deemed to be unsuitable for treatment on the NHS, very often for very good clinical reasons. The only time that it emerges that they have been put on amphetamines or something like that is when they call out their GP in the middle of the night who was the very person who said: "This was not a very good drug for you". Those people are not in the position to complain. It is extraordinarily difficult for the local doctor to complain about the clinic. This is the illustration I gave earlier about a local medical committee which actually wrote to the General Medical Council and to the organisation running the clinic and neither of them took responsibility for what happened because (a) they could not identify which doctor was responsible and (b) the clinic said it was not their business. Really it is totally unsatisfactory.

(Ms Williams) We had problems identifying the correct doctor in question and our complaint was going to the wrong surgeon. The GMC said: "Call our register if you want to check up on a doctor's training". That is all very well and there is an easy number to call but if a doctor has got a name like Smith or Jones trying to identify the right doctor is a near impossibility. One other thing is we do have anecdotal accounts, we have no proper evidence of this, of patients when they have had problems and gone back to their GP, their NHS GP has not always been sympathetic because, as you were saying, they may have turned them away from treatment or advised against that treatment in the first place. Also I think because you are out in the private market it is a bit more buyer beware.

Audrey Wise

200. Do you think that what this sort of exchange is producing is the importance of a number of different things, one of them information, one of them ability for individual redress but very importantly as well a systemic redress, the structures and things should be very, very much more controlled simply because not everything that is wrong can be expected to emerge in individual complaints?

(Ms MacKay) Yes.

Mr Walter

201. I am not sure what the outcome will be of our inquiry but obviously we are going to be looking at maybe some form of external regulations. I wonder if both organisations could perhaps help us map out where you see the boundaries between quality controls that are the responsibility of the provider and those which we see as the responsibility of an external regulator, looking at where we are today and where you think we should be going?

(Ms Meredith) The boundary between what happens inside and what happens outside the organisation seems to be quite difficult to define because, again, what we are really doing is looking at the interests of people using the service and trying to devise a system, probably not one simple single thing but a system, which can give us more confidence that the different kinds of problems we have discussed this morning can be picked up in different ways. So certainly most organisations should have their own internal checks and balances and quality controls and that is certainly coming in the National Health Service and in the independent sector; again the organisations that belong to trade organisations probably are already required to have them. One initial question about that is who accredits the accreditors. There are several different kinds of accreditation schemes out and about at the moment. As far as the consumer is concerned, I have no evidence but I think it might be quite safe to say that the vast majority of them do not have any idea of what any of the accreditation schemes really mean. So if you are going to have some internal system that you are relying on to be one of your checks and balances, then somebody has to be saying what are those schemes and on what basis have they been drawn up and to what authority are they answerable. So that might be the internal one, but even the internal one has to have a sort of external check to show it is going all right. That may not be the same thing as we were talking about earlier about the inability of individuals to make face to face complaints, and certainly we know that it is very difficult for individuals to do this. That is true of the National Health Service as well as in the private sector. Plus the kinds of vulnerability we were talking about. We know people in nursing homes, for instance, are very vulnerable. So you then come to some external monitoring. Going back to the original discussion about what principles should underpin regulations, it seems you have to start from a framework of the kind of standards that we refer to and that the Consumers' Association set out, and then show how the different parts of the system are reflecting those standards and checking on how they are doing. That is a very broad answer to a question which seems to be very complex and really at the heart of the whole issue.

202. It is at the heart of this. A secondary part of that answer, and the Consumers' Association can come in on this, is whether there should be a similar or maybe the same accreditation system in both the public and private sectors?

(Ms Meredith) If you are thinking about clinical governance now and the Commission for Health Improvement, obviously there is a temptation to say that these things should apply to both. One thing at

4 March 1999]

MS CLARA MACKAY, MS SALLY WILLIAMS,
MS JILL JOHNSTONE AND MS BARBARA MEREDITH

[Continued]

[Mr Walter Cont]

this stage is that we do not actually know whether the system being applied in the NHS is going to work, so it is an interesting question to reflect whether we should simply say yes we will use that, because we actually do not know whether that is going to be the right system. Going back to something I said earlier about trying to look at what it is that makes different parts of the independent sector different, you may come up with a kind of package of things which is slightly different but applicable in different kinds of settings, is it an institution, is it a member of the trade body, is it individuals, who is paying. Those kinds of things might affect the different ways you apply both the internal regulation system and the external one you put over it.

(Ms MacKay) I would just like to emphasise a few points. It is a very, very complex issue, partly because we are still grappling with a definition of what is health care and until that gets resolved it becomes very difficult to start defining boundaries, et cetera. But I think Barbara's point is absolutely right, there is a need for an over-arching framework, and the principles of that framework should apply equally to the private and to the public health care sectors. However, that does not mean that there is not a need for additional measures, whether they be voluntary, part of a voluntary scheme, guidance or different sets of regulations, but which actually ensures that day-to-day, on the ground, quality issues are at the top of the agenda and being checked and adhered to.

Mr Gunnell

203. A quick question to the Consumers' Association. Would you say a little more about one of the statements you made to us, when you commented that if the Advertising Standards Authority is to play a role in protecting private patients it is essential that it improves its performance with regard to ensuring that private health care providers comply with their rulings? I wonder if you can expand that a little and say what you have in mind?

(Ms MacKay) I am not sure I can answer what we have in mind, because it is difficult to find a solution. I know you will hear evidence from other groups who are probably much more knowledgeable about this particular issue, but we certainly know in instances where complaints about advertising from private clinics have been upheld, six months later, three months later, those adverts are back in the same magazines they were supposed to have been removed from and the changes have not been made. The Advertising Standards Authority, I understand, feel themselves this is a very frustrating and unsatisfactory arrangement, but until they either use the mechanisms that they have effectively or are given the powers that they need to make this work, it really is not a safety net for consumers at all, and it seems a rather unfortunate and unsatisfactory situation.

Chairman

204. This is usually where there is an advertisement claiming that the doctors are qualified in certain fields when actually they are not?

(Ms MacKay) Precisely.

(Ms Williams) Unfortunately, that is where most consumers are getting their information about these services, because there is no other source.

(Ms MacKay) We do feel this is an area the Committee could pull in, because it is quite important, we would very much support that and welcome that.

Mr Gunnell: We would hope the Advertising Standards Authority would take note of what has been said because you certainly in your report provide evidence where the mixture of commercial interest and the role of their consultations is hopelessly mixed, and it seems to me they could play a part in ensuring things are done better.

Chairman

205. Are there any other quick points from my colleagues before we conclude? Any other quick points from this group of witnesses?

(Ms MacKay) I would like very much to make a quick point on something which is in our submission and we have lobbied quite hard for, which is we really believe very strongly that there is a need to extend the remit of the Health Service Ombudsman to cover private health care. We see that as an essential step towards levelling the playing field for people who use public services and private health care services.

(Ms Meredith) Just to say again that the temptation always is to focus on acute and dramatic things and in a way we have under-played some issues which are crucial in private health care—mental health services, services for people in nursing homes, long-term care services and other services for people who may not be able to make decisions for themselves or represent their own views. The issue of advocacy and representation is crucial in all sectors of health care and it may be that this regulatory framework needs to take account of protecting particularly the interests of people who are not capable of making decisions for themselves or who need support in doing so.

206. I am very much aware there is a range of issues which we would have liked to raise with you in detail but we have not had time, and it will most likely be that we will write to both your organisations with further questions, if that is satisfactory.

(Ms MacKay) That would be fine.

Chairman: You did agree to provide us with some information on the correspondence with the GMC which would be most useful. Can I thank you all for your helpful written evidence and also for coming along today. We are very grateful. It has been most useful.

*4 March 1999]**[Continued*

Memorandum by Action for Victims of Medical Accidents

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 53)

1. INTRODUCTION

1.1 Action for Victims of Medical Accidents (AVMA) is a registered charity established in 1982 to provide advice and support to patients harmed as a result of medical treatment. In tandem with AVMA's direct services to patients, AVMA has a key role in promoting the interests of medical accident victims. Having advised in excess of 50,000 patients, both directly and indirectly, AVMA is in a unique position of understanding both the needs of medical accident victims as well as the factors leading to adverse incidents. AVMA is increasingly using this resource to work with health professionals with the aim of reducing the frequency of avoidable accidents and to ensure that where accidents do take place, the needs of the injured patient are addressed in full.

1.2 AVMA receives enquiries relating to medical accidents which have taken place both in the NHS and the private healthcare sector. Enquiries about private healthcare cover a diverse range of complaints and medical conditions. These include minor and major surgical procedures, medical care and cosmetic surgery, through to treatment provided by alternative practitioners. The consequences for patients of failures in treatment can be life changing if not life threatening. In addition to the trauma associated with a major adverse event, a patient may not only suffer serious injury, in some cases leading to the patient's death, they or their relatives may also find themselves facing substantial medical bills to cover the costs of extended or corrective treatment.

1.3 As a result of AVMA's experience of the problems encountered by private patients, AVMA has identified a number of significant problems that persist in the systems of healthcare provision in some sectors of the private healthcare market. The knowledge that AVMA has gained of adverse incidents in this sector, leads us to believe that in the interests of future patient safety, there is a need for a review of the provision of healthcare by the independent sector and following from this, the introduction of more appropriate regulatory legislation to replace the Registered Homes Act 1984. Such legislation should be tailored specifically to meet the regulatory requirements of an expanding independent healthcare sector.

1.4 This submission will concentrate primarily on the problems encountered by patients in independent hospitals.

2. AVMA'S EXPERIENCE OF MEDICAL ACCIDENTS IN INDEPENDENT HOSPITALS

2.1 By the nature of our organisation, the complaints received by AVMA from patients and relatives about private healthcare, generally relate to patients who have suffered a significant injury as a result of their treatment. Patients would not normally approach AVMA with other types of complaint, for example, complaints relating to failures in the provision of "hotel" services by a private facility or difficulties encountered with health insurance companies although both these issues may arise in relation to a more serious clinical complaint.

2.2 Patients who opt for private treatment do so not only because of the convenience that private healthcare offers but because they also believe that private treatment is necessarily going to be of a higher standard. Families may go out of their way to fund medical treatment in the belief that this is in the best interests of their relative. Patients and relatives tend to assume that as a private patient they are receiving the best standard of care available. This expectation that private care equates to "the best care" can exacerbate the situation in the event that something goes wrong. Patients and relatives are often less ready to question the standard of care even in situations where, despite a deterioration in the patient's condition, there appears to be limited if any clinical intervention in response. Certainly in cases where there have been failures in treatment, many patients and relatives feel deeply aggrieved to discover that the treatment, post-operative care in particular, may well have been of a safer if not better standard had they opted to receive care in the NHS.

2.3 Medical accidents occurring within independent hospitals tend to follow a familiar pattern with four main factors in particular featuring in many of the cases:

- (i) failures arising due to sub-standard care by the private consultant/doctor
- (ii) inadequate specialist medical and nursing cover
- (iii) lack of staff and facilities in the event of a medical emergency
- (iv) operational and administrative deficiencies

Whilst some of these factors may not be relevant to some of the larger institutions, they are issues that need to be addressed if all independent hospitals are to provide a safe standard of care.

*4 March 1999]**[Continued]*

3. FAILURES ARISING DUE TO SUB-STANDARD CARE BY THE PRIVATE CONSULTANT/DOCTOR

3.1 A significant flaw in the provision of care by the independent private sector is the lack of any effective systems for monitoring the performance of individual consultants/doctors. Private consultants are not subject to the same degree of peer review or clinical audit procedures as would be expected within the NHS. Consultants practising within the independent sector are independent contractors where ultimately, the only way that they can be held accountable is through a complaint to the General Medical Council or through legal action by the patient. There is therefore a significant risk that doctors are able to practise with a degree of impunity within the private sector without effective systems being in place to audit their work or to identify any significant failures in their practice.

3.2 If it is the case that some independent hospitals are now taking more effective action in relation to individual consultants, this is certainly not apparent when looking at the response that patients have received to complaints. It still appears to be the case that independent hospitals will advise complainants that the treatment provided by the consultant is outside their jurisdiction. There needs to be more openness about the process of consultants obtaining "admission rights" to use a hospital's facilities, and in particular, the process by which admission rights are refused or rescinded. It would also be beneficial to discover with what frequency medical advisory committees within independent hospitals are taking action to address poor performance by a doctor and where necessary, reporting concerns about individual practitioners to the General Medical Council.

3.3 It could be argued that the situation within the NHS is not significantly better. It is accepted that there have been a number of recent well-publicised cases of senior doctors within the NHS practising well outside acceptable standards where this has not been identified for many years. This demonstrates that procedures within the NHS are far from perfect but this has now been recognised. The Government is currently taking steps to address these flaws through initiatives such as the National Institute for Clinical Excellence (NICE), the Commission for Health Improvement (CHI), Clinical Governance and significant changes in clinical audit procedures to enable the practice of individual doctors to be monitored.

3.4 Whatever flaws currently exist within the NHS system for monitoring a doctor's performance, procedures do exist which can lead to action being taken to prevent a poorly performing doctor from putting patients at risk. Such procedures include internal audit meetings through to the various NHS and statutory disciplinary procedures that are currently in place.

3.5 Patients also have the additional safeguard within the NHS that unlike the independent private sector, the doctor is unlikely to be working in isolation. Problems with a doctor's practice are therefore potentially more likely to be identified.

3.6 Within the independent sector, the private consultant is generally working largely in isolation. If there are problems with an individual patient's treatment in the NHS which the consultant fails to recognise, there is some form of safety net in that the patient will also be seeing other doctors from the consultant's team or "firm". Anecdotal evidence also suggests, that where a consultant's performance is recognised by his or her colleagues to be in question, more complex cases will be diverted to a more competent colleague. The same safeguards do not generally apply within private hospitals. The patient's clinical care is the sole responsibility of his or her private consultant.

3.7 Consultants who carry out only private work, may also be unaware that their practice is not in line with current standards.

3.8 Some of these issues were highlighted in the early 1990's at a time when laparoscopic or "keyhole" surgery became the technique of choice for an ever increasing number of surgical procedures. Laparoscopic cholecystectomy (removal of the gallbladder) was one such procedure which was being increasingly performed in the private sector. Unfortunately, many of the consultant surgeons carrying out this procedure had trained as surgeons using conventional "open" procedures. When they then attempted to convert to using laparoscopic surgery, something increasingly demanded by patients, this led to a significant number of deaths and serious injury in patients undergoing surgery in the private sector, until such time as the Royal Colleges took action to introduce guidelines on training and accreditation.

4. INADEQUATE SPECIALIST MEDICAL AND NURSING COVER

4.1 This is a critical factor in a significant proportion of the cases that AVMA is asked to advise on and leads, in particular, to failures in the diagnosis and treatment of post-operative complications.

4.2 Patients undergoing what appear to be routine or minor procedures, can develop complications which may or may not be directly related to the particular surgical procedure eg cutting or stitching the ureter during a hysterectomy, the development of a deep vein thrombosis leading to a pulmonary embolism or an anaphylactic reaction to an anaesthetic drug. All surgical procedures, however minor, can lead to life threatening complications. The important factor is the early identification, diagnosis and treatment of complications if a catastrophic outcome is to be averted.

*4 March 1999]**[Continued]*

4.3 It is AVMA's belief that errors in post-operative care are an inevitable consequence of the way in which many independent hospitals operate their services and that there is no easy remedy to preventing avoidable accidents without a major revision of service provision.

4.4 Most independent hospitals will be providing operating facilities to a broad spectrum of consultant specialists: from cardiac surgery and major bowel surgery to minor general surgical procedures. Within the NHS, such patients would normally be cared for on specialist wards where the nursing staff and the medical team would be expected to be experienced in the relevant field of medicine eg orthopaedics, general surgery cardiac surgery etc. In the independent sector, unless the hospital is of a substantial size, it is unlikely that such specialist staff teams will be in place. This lack of specialist care is a fundamental deficiency in the provision of care and in turn means that the complications associated with a particular surgical procedure or medical condition may go unrecognised.

4.5 Fortunately, most patients will recover from uncomplicated surgery largely in spite of the standard of care on offer, the real test of how effective care systems are is in this very ability to act promptly and appropriately in response to developing complications.

4.6 A common scenario would be that of a patient undergoing what might be a relatively routine procedure within an independent hospital. The surgery is performed by the private consultant, assisted by an anaesthetist. The surgery is completed apparently without complication. The Consultant then returns to their other duties whether this be their NHS practice or private practice at another location, leaving the patient under the care of the hospital nursing staff and the Resident Medical Officer(s) (RMO). The Consultant will normally attend the patient at what are likely to be brief visits on subsequent days but may rely on nursing reports and clinical notes made by the RMO to assess the progress of the patient leading up to discharge.

Quality of Nursing Care

4.7 Nursing staff within the independent sector are generally having to care for patients undergoing treatment covering a wide range of medical specialities. This therefore means that patients will be unlikely to be receiving care from a nurse specialising in their particular condition eg orthopaedics, gastroenterology, cardiothoracic surgery etc.

4.8 The importance of having good specialist nursing care is arguably far greater in a private hospital where there is very limited access to specialist medical input. The patient's consultant will be reliant on the nursing staff to keep them up to speed with the patient's condition. If the nurse is not aware of the particular complications associated with a surgical procedure or the sort of symptomatology that they should be alert to, they may fail to convey what they would perceive as an unimportant change in the patient's condition. Having specialist knowledge and experience, enables nursing staff to assess whether a change in the patient's condition is significant and therefore, when they need to call for urgent medical assistance. Fortunately, as stated previously, basic nursing care may well prove adequate where the post-operative course is uncomplicated. However, should the patient develop complications, the early recognition of an evolving problem is often essential to avoid a crisis developing.

4.9 The inherent difficulty for independent hospitals is that it would be difficult, given their patient population, to provide specialist nursing care. The important issue for patients is being aware of these issues so that they can make an informed choice about their place of treatment.

4.10 Another issue that should be examined in relation to nursing staff is that of on-going professional development and training. Some small independent units may represent a potential "backwater" in terms of keeping in line with current nursing standards and practices, particular where nurses are not given the opportunity to develop expertise in a particular field(s).

4.11 Nursing staff employed by an independent hospital may also face a degree of conflict in relation to their professional duty to their patient. Whilst the hospital has a clear commercial interest in attracting patients to use their facilities, they also have an equal if not greater commercial interest, in attracting consultants to use their facilities. The hospital provides nursing care and facilities whilst the patient's treatment is the responsibility of their consultant. Nursing staff may find themselves in a somewhat invidious position in terms of having two clients to deal with, the patient and the Consultant. This could in certain situations be seen as undermining the nurse's professional duty to the patient, and potentially, the standard of care being provided.

4.12 Nurses may also find themselves in a professionally (and personally) compromising position in the event that a private consultant refuses to attend a patient after concerns have been reported. In this situation, the nursing staff can seek the advice of the Resident Medical Officer (RMO) but it is unlikely that the RMO will feel able to countermand the consultant's instructions or to insist that the consultant attends. This is a not uncommon scenario in the cases that AVMA advises on.

*4 March 1999]**[Continued]**Resident Medical Officers*

4.13 The quality of Resident Medical Officers (RMOs) is a fundamental problem for which there would appear to be no simple or at least, economically acceptable solution.

4.14 RMOs are usually very junior doctors in the early stages of their career. As with nursing staff in the independent sector, an RMO with limited experience and little if any specialist training, cannot be expected to provide the level of care and expertise that patients would not unnaturally expect to be receiving.

4.15 As a result, it is AVMA's experience that a nurse may well report concerns about a patient to the RMO, but because of their lack of experience and professional back-up, the RMO fails to recognise the significance of the symptoms described. This is not necessarily the individual RMO's fault. They can only work within the knowledge and systems available to them. For example, a particular symptom in a patient who has undergone bowel surgery may be of limited significance but it could be a critical early warning sign in a patient with liver disease. If the RMO fails to recognise the significance of a symptom displayed by a patient, it is probable that the RMO will fail to communicate this information to the patient's consultant.

4.16 An example highlighting these issues involved a young patient who underwent major surgery in a moderate sized private hospital. On the third post-operative day, the patient developed the first indications of a complication. Over the next three days, the patient's condition underwent a number of changes but his condition was not obviously critical during the early stages. The nursing notes gave some indication of a developing problem which led them to seek the advice of the RMO. The RMO's notes were uninformative if not at variance with that of the nursing staff. It is evident that the RMO failed to appreciate the significance of the patient's symptoms and arrived at an inappropriate interpretation. However, the RMO did contact the patient's Consultant but given the content of the RMO's clinical notes, it appears unlikely that the true nature of the patient's condition was communicated. These failures arising out of inexperience and poor communication combined with a failure on the part of the Consultant to respond to a change in his patient's condition, led to the death of the patient on the sixth post-operative day. If the patient's condition had been diagnosed earlier, and he had been transferred to a specialist unit, his death would most probably have been avoided.

4.17 The evidence from the cases that AVMA has dealt with, suggests that the present system of RMO clinical cover is woefully inadequate. Unless the independent sector is going to provide hospitals which mirror the staffing and facilities offered by some of their NHS counterparts, it is difficult to see how the independent sector can provide the standard of in-house expertise necessary to cater for the needs of a diverse patient population.

4.18 There are some significant improvements that could be made even within the existing RMO system starting with raising the minimum level of qualification and experience required of RMO's but this would only be a partial solution. There would, however, be a difficulty in recruiting doctors at a later stage in their careers due to the requirement for them to be in an accredited training post in order to progress up the career path.

4.19 It would also be important to look at consultant availability. It might be necessary to consider putting a limit on a consultant's NHS and private commitments. Consultants should also be required to ensure adequate clinical cover for their private patients during their absence. If the necessary specialist cover is not available within the hospital, the consultant should ensure that either they or a colleague provide such cover as the patient's condition and treatment requires.

4.20 Some effort should also be given to improving written communications, whether it be improving the standard of clinical notes or instituting more detailed post-operative medical and nursing protocols to assist with the early recognition of complications.

4.21 Another option which should seriously be considered would be that of imposing far greater restrictions on the type of surgical procedures performed within any particular independent facility. The proposal would be that hospitals would be licensed to carry out a restricted list of procedures in accordance with the facilities and the clinical cover available.

5. LACK OF STAFF AND FACILITIES IN THE EVENT OF A MEDICAL EMERGENCY

5.1 A patient who suffers a respiratory or cardiac arrest at night or at other times when the visiting consultants are not in attendance, may find themselves in a situation where there is no member of staff on site with appropriate training to respond adequately to such an emergency. Only a limited number of independent hospitals have a resident anaesthetist available at all times to deal with such emergencies.

5.2 One example is that of a young woman who went into a private hospital for a minor surgical procedure on a submandibular gland. The surgery took longer than expected but apparently there were no significant complications. Following the operation, after the patient recovered from the anaesthetic, both the surgeon and the anaesthetist left the hospital. A short time later, as a result of swelling at the site of the operation, the

*4 March 1999]**[Continued]*

patient started to asphyxiate. The RMO attempted to perform a tracheostomy, a procedure he was unfamiliar with, but was unable to find the appropriate equipment. As a result, the patient was without oxygen for a prolonged period and suffered massive brain damage leaving her in a persistent vegetative state.

5.3 Availability of experienced “crash teams” and anaesthetists within independent hospitals is an issue that requires detailed examination.

6. OPERATIONAL AND ADMINISTRATIVE DEFICIENCIES

6.1 Although most patients might prefer the comfort of a private room, this has drawbacks in terms of the provision of care. A nurse in charge of a ward is arguably in a better position to monitor the condition of her patients than a nurse in charge of an equivalent if not greater number of patients in individual closed rooms. Unless an independent hospital can provide a very high nurse to patient ratio, then the level of patient supervision is likely to be considerably less than that on an open ward.

6.2 Poor record keeping, particularly that by medical staff, is a frequent feature in many of the cases reviewed. Good record keeping is essential given that the patient’s consultant will be reliant on the records made by hospital staff to monitor the patient’s progress.

6.3 Concern is sometimes raised that the facilities within some independent hospitals are designed with presentation more in mind than the effective and efficient provision of healthcare. An anecdotal example is that of a coronary care unit which had been carpeted—not helpful in the event of an emergency if you are trying to move a crash trolley.

6.4 Many of the problems that AVMA sees relates to break-downs in communication between the hospital staff, the consultant and the patient. Good lines of communication are essential in all areas of medicine, NHS or private, but this is particularly important where the professional in charge of the patient’s treatment is not on site. As stated previously, much needs to be done to ensure the adequacy of clinical and in some cases, nursing notes. More could probably be done to improve communication using computer technology. Thought should also be given to instituting stricter protocols within the licensing requirements for the attendance of the consultant (or his/her colleague) when specific situations arise eg significant changes in the patient’s condition, and failing the consultant’s attendance, for the immediate transfer of the patient to a unit which has specialist staff available. Stricter protocols should also be introduced for the transfer of patients where their condition has deteriorated and now falls outside the expertise of the resident hospital staff and/or the conditions the hospital is licensed to treat.

6.5 A gauge of the adequacy of care available within independent hospitals could be the willingness of doctors to undergo surgery in the independent sector. AVMA’s experience is that many senior doctors have stated they would not take that risk.

7. COMPLAINTS PROCEDURES WITHIN THE INDEPENDENT HEALTHCARE SECTOR

7.1 The importance of clinical complaints to improving standards of healthcare is now generally recognised within the NHS—if not always put into practice. There is limited evidence to suggest that the same applies within the independent sector.

7.2 Independent hospitals are expected, as part of the registration requirements to have in place a complaints procedure, and to advise patients that in the event that they are not satisfied with the response, they can take their complaint to the registering health authority.

7.3 A fundamental flaw under the present system which makes the procedure largely ineffective with respect to clinical complaints is the fact that hospitals are not required to deal with any aspect of the complaint which relates to the care provided by the consultants and in many cases, this is extended to also exclude care provided by the RMO. Clearly, if a patient has suffered an adverse outcome following in-patient treatment in a private hospital, and complains, excluding any detailed examination and discussion of clinical treatment, is inevitably going to mean that the response is at best going to deal only with a limited aspect of the complaint and at worst, will fail to even touch upon the main substance of the complaint.

7.4 As with patients in the NHS, anyone who has suffered a serious adverse clinical event, is firstly concerned that someone acknowledges what has happened and if appropriate, apologises. Failure to do so, is one of the significant factors in patients resorting to legal action. Secondly, patients and relatives want evidence that where failures have been acknowledged, action will and is being taken to remedy the cause of the failure to prevent a recurrence. Such action might, for example, include changes in clinical or nursing procedures, a disciplinary enquiry or staff undergoing retraining. Finally, where a patient has suffered substantial injury, distress or losses as a result of the incident, they may well wish to seek financial compensation. Ultimately, patients need to know that their voice has been heard, that their concerns are not being ingored and that by complaining, they will prevent this happening again.

4 March 1999][Continued

7.5 Given the inadequacies of the present complaints system within the independent sector, patients who have suffered a serious adverse event are unlikely to receive an adequate response to concerns about treatment. This is certainly AVMA's experience of complaints handling in the private sector.

7.6 The concern is not just that patients are left without an explanation or acknowledgement but that the failures leading to the adverse event will not be properly examined and as a result, action will not be instituted to prevent future failures in care.

7.7 Patients are advised that they can complain directly to the Consultant but with no independent examination of the events surrounding the complaint, the patient is not only at a significant disadvantage, there is still a considerable reluctance for health professionals to acknowledge failures in their practice. In addition, it may well be the case that the cause of the complaint rests both with the clinician and the hospital, with neither being prepared to accept responsibility. This highlights the need for an independent investigation of any serious adverse event.

Health Authority Investigation of Complaints

7.8 Complainants dissatisfied with the hospital's/consultant's response to their complaint can refer the matter to the registering health authority. AVMA's experience is that firstly, very few complainants are made aware of this avenue, and secondly, that health authorities are poorly equipped to respond to such requests from patients.

7.9 Health authorities vary considerably in terms of how they see their role in responding to complaints. In many cases, health authorities will interpret their role only in terms of those aspects of the complaint that are strictly relevant to the licensing requirements eg facilities, record keeping etc. On the basis that the legislation is primarily concerned with nursing and residential homes, it is to be expected that an investigation based on current legislation is going to prove inadequate. Health authorities will normally not deal with clinical aspects of a complaint, effectively excluding the most serious complaints about treatment provided within the independent sector.

7.10 There have been a very limited number of examples of health authorities taking a broader view of their role resulting in a more detailed investigation of all aspects of the complaint. However, this is very much the exception rather than the rule. Most health authorities simply do not deal with a sufficient number of complaints about the independent sector to develop an effective protocol for investigating complaints.

7.11 The health authority in raising criticisms about an independent facility may also be mindful of the fact that equivalent deficiencies in NHS provision may well exist within their authority leaving them exposed to counter-criticism. There is also a degree of interdependence between NHS and independent provision. Increasing numbers of NHS patients are being treated under contract in the private sector and those patients who opt for private care, relieve the NHS of the costs of treating many of the routine surgical cases as well as taking pressure off the NHS waiting lists. These factors may mean that in some cases, a health authority may be reluctant to respond adequately to concerns raised by a patient or their relative. It is AVMA's experience that complaining can be a very lengthy process and considerable persuasion is usually required to achieve anything other than a very limited investigation by the health authority.

7.12 Those independent facilities providing specific categories of care, in particular, terminations of pregnancy and infertility treatment, are subject to additional regulation and inspection in accordance with the relevant legislation (Abortion Act 1967, Human Fertilisation and Embryology Act 1990). Patients are not always aware of this additional avenue of complaint, particularly with regard to terminations of pregnancy, although the Human Fertilisation and Embryology Authority (HFEA) does produce a considerable amount of useful literature for patients. More use could be made by patients of these potentially useful sources of independent investigation and in addition, the experience of the HFEA of responding to concerns raised by patients could possibly assist in the establishment of procedures for the independent investigation of complaints within the independent sector as a whole.

Recommendations for Improving the Investigation of Adverse Events

7.13 An essential element of an effective complaints procedure is access to an independent investigation. This is not only for the benefit of the complainant; an independent assessment of the treatment is important in terms of identifying any failures in the treatment in order to recommend action on the part of the healthcare provider.

7.14 AVMA would recommend the introduction of a statutory complaints procedure. This could be along similar lines to the NHS Complaints Procedure with the emphasis on resolving complaints at the local level but failing that, access to a fully independent investigation. It may be possible that such a complaints procedure could be linked into the NHS procedures at the second stage. The costs for such investigations could be levied from individual institutions at the time of licensing.

4 March 1999][Continued

7.15 To effect this, the licensing should be subject to operating the requisite complaints procedure and health professionals working within independent facilities should be required by contract to co-operate with any complaints investigation.

7.16 NHS complainants have access to their local Community Health Council (CHC) to advise and assist them with pursuing a complaint. Private patients are not entitled to assistance from their local CHC. Some thought should be given to where private patients might access advice or be able to report concerns about private treatment in the event that they feel unable to pursue a complaint.

7.17 There will be many situations where health professionals are not working within a recognised facility. In this situation, we should be looking to professional bodies to put in place complaints procedures able to deal with complaints which currently fall outside the professional conduct or health procedures. The General Dental Council is investigating the introduction of such a complaints procedure with respect to private dental treatment and other statutory professional bodies should be encouraged to follow their example.

Alternative/Complementary Medicine

7.18 With respect to those practitioners who are not currently subject to a system of statutory professional registration eg most branches of alternative/complementary medicine and counselling services etc, there are little if any safeguards for patients seeking treatment. In the absence of instituting statutory regulation of all these individual practitioner groups, consideration should be given to some form of "licensing". The arguments against would be that of the costs involved as well as the need to establish standards against which a practitioner's practice can be assessed. However, the present situation is clearly not satisfactory where any individual can set themselves up in practice to "treat" patients, presenting a considerable risk to what is potentially a very vulnerable patient population.

Independent Inspection

7.19 In recognising the importance of monitoring and maintaining standards within the NHS, the Government must also look at monitoring standards operating in the independent sector. In the same way that school inspections apply to both state and independent schools, it could be strongly argued that bodies such as the Commission for Health Improvement should apply both to the NHS and the independent sector with requirements for the independent sector to provide clinical audit data etc.

Role of Insurers

7.20 Some consideration should also be given to the role of healthcare insurers in maintaining standards in the independent sector. It is in their interests and that of their subscribers to ensure that care they are providing cover for is not only cost-effective but is also of a good standard. If a medical accident takes place, the costs of treatment are likely to increase considerably as well as the potential for adverse publicity.

Deaths in Private Hospitals

7.21 AVMA has seen a number of very worrying examples of cases where patients have died whilst undergoing treatment in a private hospital, in circumstances which clearly warranted a Coroner's investigation and yet the Coroner has been dissuaded from the necessity of a post-mortem examination. Whether this is as a result of a lack of knowledge on the part of medical staff of the requirement to report certain categories of death to the coroner is not clear. However, this is an issue that should be dealt with, possibly through legislation. It is true that many cases within the NHS are also not reported to the Coroner or subject to an Inquest but in most cases there will be some form of internal investigation or review of the case and/or a hospital post-mortem. It is unclear to what extent this is mirrored in the independent sector but this is an issue that needs to be addressed within the legislation.

7.22 The National Confidential Inquiry into Perioperative Deaths (NCEPOD), in its 1995-96 report, commented on the disappointing response of the independent sector to participating in its inquiry. The independent sector should be encouraged, if not required, to participate in what is a very important inquiry process for monitoring and improving standards in surgery.

Legal Action

7.23 It might be assumed that legal action represents an effective alternative to complaining. This is not the case. Legal action is concerned primarily, if not exclusively, with whether compensation should be paid. It is not concerned with whether a particular hospital or consultant is continuing to put patients at risk nor can it offer injured patients and their families the sort of answers and resolution they need. In any event, for a high proportion of private patients, legal action is not even an option because of the very high costs

4 March 1999]

[Continued

involved. Legal action can never and should never be a substitute for an effective complaints process although in the absence of an alternative, patients often have to resort to legal action. This is not to say that patients should not sue where there is a clear entitlement to compensation but they should not be forced to litigate simply to get answers to their concerns.

8. STATUTORY REGULATION OF PRIVATE AND INDEPENDENT HEALTHCARE

8.1 The Registered Homes Act 1984 was originally drawn up primarily with residential and nursing homes in mind and is clearly no longer adequate for the regulation of today's large independent hospitals. New legislation tailored to meet the present and future development of the independent sector, taking into account the increasing convergence of state and independent healthcare provision, is now long overdue.

8.2 In reviewing the regulation of the private sector, the legislation needs to include more detailed guidance in order to ensure that hospitals are appropriately equipped and staffed to carry out a nominated list of surgical procedures. This will necessitate introducing a detailed grading system for independent facilities, with those at the top end of the scale being able to carry out a full range of surgical procedures, and the lower graded institutions being able to carry out only a limited range of procedures in accordance with their staffing and facilities. This is with a view to preventing major surgical procedures being performed in hospitals not equipped to deal with anything other than routine minor procedures.

8.3 The legislation should also address some of the concerns relating to private healthcare professionals including a requirement for them to participate in the investigation of complaints and greater statutory responsibilities to be placed on Medical Advisory Committees to audit and monitor the practice of any consultant with admission rights to their facility, and to act in the event that a consultant's practice is called into question.

8.4 Serious consideration needs to be given to the role of RMOs and whether it is still acceptable for a junior doctor with limited experience to be in charge of a diverse patient population. If RMOs are going to continue to provide medical cover, then revised minimum qualifications and experience should be included in the legislation.

Licensing and Inspection

8.5 It is recognised that the current system of health authority inspections of private hospitals has a number of serious flaws¹, not least that health authorities have other priorities that may well take precedence.

8.6 One recommendation would be that the licensing and inspection of private facilities should be taken over by a regional body, independent of local health authority provision. This body would also be responsible for the investigation of complaints, albeit via a separate department.

8.7 Concentrating the registration and inspection within regional bodies, possibly based in a health authority, would help to ensure more uniform standards within the independent sector. It would also enable the personnel responsible for registration and inspection to develop greater experience and expertise than is currently possible within small under-resourced health authority departments.

January 1999

Memorandum by Action for the Proper Regulation of Private Hospitals

THE REGULATION MONITORING AND INSPECTION OF PRIVATE ACUTE HOSPITALS THE COMPLAINTS PROCEDURES RELATING TO SUCH PROVISION (PM 49 ANNEX A)

CONTENTS

EXECUTIVE SUMMARY

Para.

1. APROP—BACKGROUND NOTES

2.0 Registered Homes Act

2.1 The Industry

2.2 Private Hospital Sector—Statistics

2.3 Private Hospitals—Current Situation

¹ 1994 RCN report, "An Inspector Calls".

*4 March 1999]**[Continued]*

- 2.4 Private Hospitals—Monitoring
- 2.5 The Admitting Consultant
- 3.1 Litigation—Hospitals
- 3.2 Litigation—The Consultant
- 3.3 Cost of Litigation
- 3.31 Conditional Fees
- 3.32 Legal Aid
- 3.33 The Bolam Test
- 3.34 Out of Court Settlements
- 4.0 The General Medical Council (GMC)
- 5.1-5.8 Complaints System
- 6.1 Comments
- 6.2-6.6 Recommendations

EXECUTIVE SUMMARY

APROP is asking for new legislation to replace the 1984 Registered Homes Act (Part 2) and Statutory Instrument 1578. These were designed for nursing homes and not for private acute hospitals using modern highly sophisticated medical and surgical procedures.

The new Act should provide for the effective regulation, inspection and staffing of private hospitals and for the patients to have the same statutory rights of complaint as apply in the NHS including access to an Independent Review Panel and the Health Service Commissioner (Ombudsman).

Until such legislation is in place, patients who have been complainants in the private sector should be co-opted onto, or appointed to, the Working Group of the Independent Healthcare Association (IHA), the industry trade association, which is considering a new complaints procedure to recommend to its members. The IHA has been approached, but to date has rejected the offer of an APROP member to join this Group.

New legislation should provide for the monitoring of clinical care, medical staffing and back-up facilities.

The present situation, where the consultant is not employed by the private hospital, unlike in the NHS where consultants are employees, allows the hospital to disclaim any responsibility for what the consultant does. In effect the consultant practises unsupervised and uncontrolled. This must be changed. (See article opposite, Independent 14.1.99).

Both the healthcare industry, with a turnover of more than £13 billion a year including nursing homes, and the consultants, with large incomes from private practice, will fight changes in the status quo and demand a measure of self regulation. That should not be allowed to happen. It is a matter of human lives, not stocks and shares.

The following memorandum covers a number of subjects which demonstrate the weaknesses of current legislation and the ineffectiveness of control in the independent healthcare sector.

A separate section covers the complaints procedure.

RECOMMENDATIONS

APROP respectfully suggests that the Committee on Health recommends to HM Government that it introduces new legislation to protect private patients and to give them the same rights of complaint as obtained in the public sector.

APROP further suggests that the Government document "A First Class Service" provides virtually all that is required to accomplish this. Private acute hospitals could be incorporated into the plan with little effort or expense. As "A First Class Service" is a 10 year year plan, legislation is required to cover the intervening period however.

APROP (ACTION FOR PROPER REGULATION OF PRIVATE HOSPITALS)

1. APROP was formed in 1998 from a disparate group of people, all of whom had suffered in different ways from the inadequacies of private acute hospitals. It is a loosely formed association whose members continue to act on their own behalf, but also in concert, with the aims of improving private hospitals and of protecting their patients. It should be emphasised that APROP is not out to harm the private sector, only to improve it. Members are all medically insured.

4 March 1999]

[Continued

APROP is campaigning for the effective regulation, inspection and staffing of private hospitals and for a statutory complaints procedure at least as good as that provided for NHS patients with the right of appeal to an Independent Complaints Review Panel and, if necessary, access to the Health Service Commissioner.

APROP's main objective, therefore, is to have Part 2 of The Registered Homes Act 1984, and Statutory Instrument 1578, replaced by new legislation designed for modern hospitals performing highly sophisticated medical and surgical procedures. (The 1984 Act was intended to regulate private nursing homes.)

In order to achieve the above objectives, APROP has consulted Government Ministers, Opposition Front Bench Spokespersons, Members of Parliament of the three main parties, officials of the Department of Health, senior members of the medical profession, senior officials in the healthcare industry, private hospital groups, medical insurance companies, the Insurance Ombudsman and The Lord Chancellor. We have made extensive use of the media.

APROP's founder members (Committee) include:

Mrs Caroline Buckley	Matthew Buckley	Brian Burwash
Andreas Charalambides	Mrs Janice Ferarri	Graham Maloney
	Mrs Wendy Ryb	
Ms Samantha Ryb (Secretary)		John J Lambie (Chairman)

A number of APROP non-committee members are involved in litigation and cannot take part in the Health Committee Inquiry. Others are available to give evidence, but the combined experiences of the Committee members demonstrate most of the deficiencies and injustices found in the private healthcare system. It was not thought appropriate to flood your Committee with submissions from individual members of APROP. Their cases differ in detail, but follow similar patterns of grief, frustration and injustice. Additional case histories are available should the Committee require them.

2. THE REGISTERED HOMES ACT 1984 (PART 2) AND STATUTORY INSTRUMENT 1578

The most appropriate way to consider this Act, and the regulations imposed by the Statutory Instrument, is to examine how effective they are when applied to private healthcare.

2.1 *The Industry*

The turnover of the private healthcare industry in the UK is more than £13 billion. The share of the private acute hospital sector, including private facilities in public hospitals, is in the region of £2.3 billion. It is important to remember how big this industry is and that its primary responsibility is to its shareholders. One APROP member was told by a private hospital manager that the consultant about whom she complained was more valuable to the hospital than the patients. He brings in the business.

The trade organisation for the industry is the Independent Healthcare Association, which has charitable status for some reason.

2.2 *The Private Acute Hospital Sector—Statistics*

The private hospitals referred to in this memorandum are private acute hospitals. There are about 220 such hospitals in this country, providing approximately 11,000 beds. About one third of these hospitals are registered as charities. Most private hospitals are owned by three main groups, BUPA, Nuffield, and the General Healthcare Group. BUPA also has a medical insurance division, which may raise questions of conflict of interest. Fewer than 10 per cent of private hospitals have more than 100 beds and many have fewer than 50.

More than 6 million people are medically insured and 1 million attend private hospitals each year. (One million patients a day are treated in the NHS).

2.3 *Private Hospitals—Current Situation*

The anachronistic relationships between private patients, private hospitals and admitting consultants must be unique to this country and not understood by most people.

The patient's contract with the hospital is basically for nursing, accommodation and food.

The patient's "contract" with the consultant is for clinical care.

The consultant's contract with the hospital is solely for the use of the facilities the hospital can provide. He is, in effect, self-employed. The fact that he is not employed by the hospital becomes evident if there is a medical "accident" or if medical negligence is suspected. The hospital abrogates all responsibility. This is passed on to the consultant.

4 March 1999][Continued

The promotional points emphasised in private hospital brochures are:

1. The speed of receiving an appointment with a specialist and of starting treatment.
2. The comfort and privacy of an en-suite room.
3. Excellent nursing.
4. The personal care of the consultant.

In practice three out of four of these claims can be misleading.

1. This is undoubtedly true, and especially important in view of the waiting lists in the NHS.
2. A private room can be a serious hazard if the patient cannot use the emergency button. (see Burwash and Charalambides—File 2).
3. The patient is not told that the nurse has to be a generalist, caring for nearly all types of case. Often they are agency nurses. NHS nurses are trained in a given specialty and re-trained if they change to another field. When agency nurses are employed in the NHS they work with a specialist team of nurses and doctors.
4. The problems of relying on the consultant for clinical care are covered later.

2.4 Private Hospitals—Monitoring

Most private hospitals are licensed by an Area Health Authority (AHA). These AHAs must inspect the hospitals twice a year, once without prior notice. The inspections are perfunctory and have been carried out by AHA staff without medical or nursing experience. In one way such experience is unnecessary as the inspectors are FORBIDDEN TO ENQUIRE INTO ANY ASPECTS OF CLINICAL CARE. The inspectors' powers in this area are limited to agreeing the staffing levels of nurses. (See DoH letter under "D", file 2). It is only recently that visit reports have become available to the public.

The Royal College of Nursing have long called for a National Inspectorate for both NHS and private hospitals. The RCN's recommendations have been superseded in the DoH publication, "A First Class Service". Unfortunately the plans put forward in this document do not yet include the private sector.

There is one way by which an AHA can help a private patient who is dissatisfied with the response to a complaint. The AHA has the authority to carry out a thorough investigation of the case. It is reluctant to do so because of the time and cost, and of course the hospital resists strongly any such suggestion. (See Maloney, File 2).

After one such investigation which produced a critical report the AHA concerned offered to hold joint complaints hearings with the hospital. This was rejected out of hand as it was not required by the 1984 Act! (See Maloney, File 2). This demonstrates well the lack of authority the AHAs have over the hospitals they license.

Lack of monitoring is also evident in the dearth of meaningful information published by the private sector. Nothing is known of mortality, re-admission or infection rates, the number of patients who exceed their expected stay or who are transferred to intensive care or long stay facilities in the NHS. These vital statistics are not published.

Each hospital should have a Medical Advisory Committee consisting of a panel of admitting consultants (most of whom usually work together for the local NHS Trust). Its responsibilities includes monitoring the clinical standards maintained by their fellow consultants, auditing the progress of patients who are not making the expected rate of recovery, examining the need for new equipment etc. With the known propensity of doctors to look after their own, well demonstrated by the much publicised cases in Bristol and Kent, not much credence can be given to such committees being an effective assurance that the highest clinical standards are being maintained. In the experience of the writer of this memorandum, the Medical Advisory Committee of the hospital where his wife was critically ill did not meet for three months (See Lambie, File 2).

2.5 The admitting consultant

Admitting consultants are appointed by the management of the hospital with the approval of the Medical Advisory Committee. Usually they have part-time contracts with a local NHS Trust, but they do not have to be NHS consultants. The requirements for selection are registration with the General Medical Council (GMC) and membership of a medical defence society. The assumption is made that if they have a consultancy with the NHS that, in itself, guarantees that their standard of proficiency in their specialty is of the highest. As pointed out above, however, there is no effective monitoring system in place; neither is there any requirement for the consultant to undergo periodic refresher training. The independent sector claimed in the past that the latter was covered by the NHS. Sadly, once again, recent events have disproved that theory, but it could become true if the recommendations in "A First Class Service" were implemented.

4 March 1999][Continued

As the hospital does not employ the consultant, it has virtually no control over how he practises. For instance, surgeons can operate in areas outside their expertise and perform operations in hospitals without the necessary back-up facilities such as ICUs and "crash teams". (See Ryb, Charalambides and Burwash cases, File 2).

A shortage of ICU beds in the private sector is not surprising as it costs over £1,000 per patient per day to run such a unit. For it to be classified as an ICU it has to be staffed and equipped to NHS standards 24 hours a day, seven days a week.

Crash teams provide emergency resuscitation. The Royal College of Anaesthetists recommends that all hospitals should have crash teams providing 24 hour cover, properly staffed and equipped and with an anaesthetist on the team. The latter is necessary to provide life saving duties in the very few minutes available. Few, if any, private hospitals can provide this level of service. Very few have resident anaesthetists.

As stated above, one of the main attractions sold to the public is the much advertised fact that the patient's care is exclusively in the hands of the consultant. Patients do not stop to think, nor are they told, that the consultant works for most of his time for the NHS and probably has at least one other admitting consultancy elsewhere. He is on site for very little of the day and not at all at night. The only medical cover permanently available is a Resident Medical Officer (RMO), a comparatively inexperienced doctor. The RMO, although employed by the hospital, is responsible to the consultant and can only act on the consultant's instructions. Yet if there is an emergency the RMO is the only doctor available and has to do his best until the consultant can get back to the hospital. (See Burwash, File 2).

Most medical consultants are skilled, dedicated professionals, but there are some, as in all professions, who are sub-standard in skill and integrity. Private practice is a money making exercise and, because of this, some succumb to temptation and abuse their privileged position. As there are so few restraints on what they do, this is not surprising.

Some medical insurance groups and at least one hospital group claim to be working towards removing incompetent consultants. One can wonder why this has taken so long. The Ryb case quoted in this report happened nine years ago, and essentially nothing has changed. APROP does not flatter itself that its efforts have persuaded the industry to start to "clean up its act". Much more likely the combination of consistent bad media coverage and, more important, the imminent inquiry by your Committee will have forced their hands. The scale of the damage done to women in Kent, unreported over many years, must have been an added incentive. Most of all, however, they will be planning to retain as much self-regulation as they can. There is a lot of money at stake.

Ironically one of the most critical articles on consultant care in private hospitals, "Accreditation of doctors in the private sector", was co-authored by Dr Vallance-Owen, medical director of BUPA, ("Clinical Risk 1996 2, 27-30). (See File 2, section "V"). He called for an audit of the performance of admitting consultants, partly for the benefit of the patient and partly for commercial reasons such as protecting the reputation of the hospital. He refers to the UNSUPERVISED practice of the consultant and asserts that the private hospital is a less safe place to be than a public one.

"Although generalising a little, it is the case that private practice offers fewer of the safeguards and supports that help to minimise patient risk in the public sector".

To his credit Dr Vallance-Owen has also called for the inclusion of private hospitals in the work of the proposed Commission for Health Improvement, a request which so far has been rejected.

A recent TV programme, "Here and Now", featured an APROP member who, following heart surgery in a private hospital, nearly died in the public hospital to which he was rushed with an undiagnosed bowel complaint. A gastroenterologist's comment, somewhat tongue in cheek was, *"Well they are heart men. You can't expect them to know about tummies"*, a pointed comment on the dangers of a consultant's narrow specialisation when working alone and unsupervised. Consultants tend to forget how much they rely in the NHS on their senior registrars and consultant colleagues in other disciplines.

CONCLUSION

There is no effective monitoring of clinical care in the private sector. Private hospitals and consultants are virtually uncontrolled in this respect. Nevertheless, most patients are full of praise for their care and treatment. In the minority of cases where things go wrong the patients are in serious trouble as will be explained in the "complaints" section. One safeguard which could be put in place quickly would be a limitation on what treatments can be offered in a hospital according to the staff and back-up facilities available, usually a function of the number of beds.

4 March 1999][Continued

3. LITIGATION

3.1 Hospitals

The Independent Healthcare Association (IHA), the industry trade association, has issued a Code of Practice for member hospitals to use. Hospitals are recommended to include this in their registration documents. Very few do so.

The IHA currently has a Working Party formulating a new, improved Complaints Procedure to recommend to its members, but so far has refused to appoint any patients' representatives to it, an archaic stance these days and contrary to the policy of similar organisations. For example, The Association of British Pharmaceutical Industries (APBI), representing another very large healthcare industry, has a "Prescription Medicines Code of Practice Authority" with several "lay" members.

Normally, when there is a complaint about a hospital's care of a patient, all that is sought on the patient's behalf is an explanation and, when appropriate, an apology. Because of the prevaricating tactics and intransigence of the hospital officials, however, (See solicitor's letter Lambie Case, File 2) the complainant is forced to sue. (See Burwash, Charalambides and Ryb cases, File 2). The legal situation is particularly difficult when both the hospital and the consultant are involved. (Ryb and Charalambides). In any event the prospects of challenging a £13.5 billion industry in court is a formidable and expensive undertaking. Needless to say, the defence uses only top lawyers.

3.2 The Consultant

There is no complaints procedure for those in dispute with consultants. The doctors are told by their defence societies to refer the matter to them and not to deal with patients personally, despite GMC guidelines to the contrary.

The matter can sometimes be put to the hospital's "Medical Advisory Committee", but if that does not satisfy the complainant the alternatives left are litigation and the GMC.

3.3 Cost of Litigation

The process of suing is frightening, especially for the elderly, the less articulate and the middle income groups. A solicitor is needed who is an expert in medical litigation, hospital records must be withdrawn, a reliable and professionally respected expert witness must be employed and a barrister with medic-legal work. The costs can reach hundreds of thousands of pounds.

Obviously the very rich have no problem in financing a case and securing the best lawyers.

3.31 Conditional Fees

The Lord Chancellor's suggestion is that people who do not qualify for legal aid should use solicitors who accept cases on a conditional fee basis (no win—no fee). Obviously for this to work the firm has to be almost certain of winning (it is said that it needs an 80 per cent chance before undertaking the work). The percentage must be in that region, as it can lose a great deal of money if the case is lost. Obviously the likely size of any settlement is another important factor in deciding whether the solicitor takes the case.

3.32 Legal Aid

Not long ago the Lord Chancellor's department understandably issued a ruling that Legal Aid for medical litigation cases will be approved in future only if the solicitor's firm chosen is on approved lists held by the Law Society and AVMA (Action for the Victims of Medical Accidents). Too many solicitors had been undertaking work for which they had little competence, to the detriment of the client and of legal action funds.

On 14 January 1999, Mr Steve Orchard, Chief Executive of the Legal Aid Board, soon to be replaced by a new Legal Services Commission, issued a consultation paper which suggested that much stricter criteria should be applied before legal aid is granted. If the estimated chance of success is 60 per cent to 80 per cent, then the estimated damages won will have to be at least three times the cost. As the chance of success reduces, the return must rise. A 50 per cent to 60 per cent estimate of success requires an award of more than four times the costs. Below 50 per cent the litigant has to find a solicitor willing to accept the case on a conditional fee basis.

As stated above and elsewhere in the memorandum, this is most unlikely to happen because of the complexity and cost of medical litigation and the resources of the defence. The less privileged in the community will become even more underprivileged if this proposal is applied to medical litigation. There is

4 March 1999]

[Continued

virtually no chance of solicitors accepting conditional fees against such odds. Estimating accurately in percentage terms the chances of winning medical negligence cases can hardly be compared with, for example, the odds on successfully suing a local authority because a loose paving stone caused someone to break a leg.

The "Independent" article reporting on the consultation paper and the reaction to it can be found in File 2, section "L".

It may be that personal injuries will be excluded from these proposals. There have also been suggestions that solicitors could insure themselves against the costs of losing Conditional Fee cases if they use the 80 per cent chance of success criterion.

3.33 *The Bolam Test*

About 40 years ago a legal precedent was created in medical negligence cases. This is known as the Bolam Case. If defence lawyers can find two specialists, in the same field of medicine as the defendant, who are willing to testify that they might have used the same technique or procedure as the defendant, the latter is vindicated. That applies even if the expert witnesses no longer use it themselves. The writer thinks that this ruling no longer applies in other countries where it used to be accepted law. If it is still used in English courts then surely it should be abolished.

3.34 *Out of Court Settlements*

When defence lawyers think that they will lose, they usually offer to settle out of court. Most people know what this means, but not all know the implications. The defence solicitors gauge the least amount they think the judge will accept and pay that into court. The litigant then has to gamble. (Ryb Case—File 2). If the litigant refuses the offer and asks for a hearing the judge may think that the offer is fair. The litigant then has to pay the costs of both sides. He could win the case and bankrupt himself. No apology or admission of guilt is normal and defence lawyers may try to impose a gagging clause.

4. THE GENERAL MEDICAL COUNCIL (GMC)

The purpose of the General Medical Council is to protect patients and to guide doctors. When the writer reported a surgeon for professional negligence in 1995, the only sanctions then available to the GMC were removing the doctor from the Register (striking him off) or suspending him from the Register, neither of which were asked for. They were unable simply to censure him.

Since then the Medical (Professional Performance) Act 1995 was passed, coming into effect on 1 July 1997. This was the most important extension of the GMC's powers since it was founded in 1858. The offence is known as Seriously Deficient Performance and if found "Guilty" the doctor's registration will either have conditions attached to it or it will be suspended. The doctor's failures have to be repeated for this charge to be made and a sworn statement has to be lodged by the accuser.

If a patient or next-of-kin wishes to report a doctor to the GMC, usually for "serious professional misconduct", this can be done at first by discussing the matter and then by sworn statement. Normally the complainant would have first collected all relevant papers and documents from the hospital and had these assessed by an independent medical expert. Here lies the first hurdle.

There are surprisingly few doctors in any given specialty and through training, seminars, conferences and publications most of them know or know of each other. It is difficult for them to give evidence against a colleague in a "trial" which is in effect what the GMC conducts under the legal powers granted it by Parliament. Nevertheless there are lists of medical experts available.

The GMC staff are helpful and understanding and have 25 lay members who represent the public. Nevertheless, if a complainant is called to give evidence before defence lawyers and expert witnesses this can be a daunting experience for most lay people.

CONCLUSION

If an admitting consultant transgresses, and refuses to offer an explanation or apology, the complainant has only two alternatives: go the GMC or to law. Both are frightening, unpleasant and expensive. Patients should not be placed in such a position. The consultant must be made responsible to some authority with teeth and the hospital must be held responsible for the patients under its care.

The following submission, Para 5 to 5.91, was written by APROP member, Mrs Fiona Hodgson, and intended for the Independent Healthcare Association. As it cannot be improved upon by the writer of this memorandum, it is being submitted as part of the APROP memorandum and the IHA will receive its copy at a later date. Inevitably there is some duplication of what can be found elsewhere in APROP's presentation.

4 March 1999][Continued

PARAGRAPH 5

SUBMISSION TO IHA ON THE NEED FOR A PRIVATE PATIENTS COMPLAINTS SYSTEM

5.1 INTRODUCTION

This paper deals with some of the issues raised by patient's complaints about clinical care in the private sector and specifically about complaints against consultants. It deals with the position of patients in the private sector, describes the present complaints procedure, compares this to complaints procedures for other trade and professional bodies and makes recommendations for improvements.

It is taken as read that healthcare should be carried out for the preservation of human life and for the avoidance of suffering. It thus follows that all hospital systems should be designed to meet this basic purpose and that therefore the needs and safety of the patient must be paramount.

The private hospital companies, however, exist to make a return on their capital employed. They therefore try to attract patients to use their hospital with glossy brochures that promise the patient the best of care. However, the hospital companies define the consultants as their primary customers and look to them to bring the patients into their hospital. There is therefore an inherent conflict of interest, which can rebound to the patient's disadvantage when things go wrong.

In the private sector, the admitting consultant is responsible for the patient's clinical care. This contrasts with the situation in the NHS where it is the hospital that has that responsibility. In spite of the private hospital companies describing their industry as "healthcare", when the patient complains about clinical treatment he has received, they distance themselves from the situation and the patient is told that he should take the issue up with the consultant. Thus the hospital company will deny all responsibility for the clinical care.

It is a sad but accurate reflection of the attitude of private hospital companies towards patients that they have not invited any patient representatives on to the IHA Working Group looking at Complaints in spite of having been requested to do so. It would appear from this that their first instinct has been to satisfy the demands of their industry, the insurance companies and the doctors.

For the patient the present situation is totally unacceptable and changes urgently need to be made.

The IHA attitude contrasts markedly with other trade associations. The Association of British Pharmaceutical Industries (APBI), another trade association representing a large healthcare industry, has a "Prescription Medicine Code of Practice Authority". Several "lay" members sit on it. This is agreed practice nowadays.

5.2 BACKGROUND

There is a legitimate and substantial public interest in arrangements to ensure that professional activities in whatever field are conducted effectively and with integrity.

In *"A Guide to Standards in Private Practice"* produced by the Private Practice Forum it states:

"standards of competence, expertise and facilities in private practice should be comparable to those in the NHS".

Thus it must follow that the minimum standard of care a patient should expect to receive should be at least as good as if he or she had been admitted to a NHS hospital. This most definitely not the case with the handling of complaints.

Consultants working in a private hospital are self-employed and this contrasts with their NHS work, where they are employed by the hospital under contract. The clinical responsibility for the patient in a private setting rests with the admitting consultant and, in consequence, except in very extreme and persistent cases, the private hospitals do not accept any responsibility for the conduct of the consultant.

Most patients entering a private hospital do not understand the subtle but critical difference in these relationships. None of it is spelt out in the glossy brochures advertising the private hospitals that talk about "our staff" and "our consultants" on the same page. Thus the patient is led to assume that the private hospitals do take some responsibility for the consultants.

Moreover it is the private hospital companies which grant admitting rights to consultants at their hospitals. In most cases, it would seem the case that because a consultant is holding down a NHS consultancy, it is sufficient qualification to grant him/her admitting rights to a private hospital. We did not learn of any hospital companies that consult the Colleges of the specialty that a consultant holds to ascertain the quality of his work, neither did we learn that the companies consulted others within the specialty held by a consultant to whom they were considering giving admitting rights. This is not consistent with the advertising in many

4 March 1999][Continued

private hospital brochures that talk about “consultants and other clinical specialists meet the highest standards” or similar forms of words that lead a patient to make the assumption that “only the best” consultants are allowed to work at the hospital.

Because private healthcare is perceived as expensive and patients are directly paying for their treatment and stay in hospital, most think that they are buying the best care and certainly standards of care at least as good as those available through the NHS. This impression is encouraged by the private hospitals’ brochures which contain phrases such as “we strive to offer the highest levels of patient care”; “is committed to excellence and quality through the provision of specialised healthcare services” and other such phrases.

Moreover, this notion is further compounded by the fact that the average patient has an expectation that he or she can rely on the professional title of “consultant”. However, not every doctor is a good doctor and not every consultant is a good consultant. It is not easy to dismiss a consultant from a NHS post (but is easier now with the advent of trusts). Many of them have contracts for their working life, which are extremely difficult to terminate prematurely. At the present time, the general public is not given access to information to be able to assess the quality of the consultant care that they are purchasing, but, from the advertising of many private hospitals, they will have been led to believe that the hospital itself has selected the best consultants for each specialty. This lulls the patient into a false sense of security.

Irrespective of how good the consultant may be, it must be recognised that he is in the hospital for a short time only each day, and not at all at night. He may not be easily contactable because of his NHS duties and work in other private hospitals.

When things go wrong with medical care, some patients (or their relatives) will complain direct to the consultant, and this can often result in tension and breakdown in that relationship. Others will feel in a weakened state and therefore unable to tackle the consultant “head-on” and they look to the hospital for help. The fact that the brochures talk about “our consultants” and “highest levels of care” lead the patient to make the assumption that the hospital will assist them, which is not the case. This enhances the terrible feeling of letdown and helplessness that patients experience when medical care has been damaging.

The argument is often put forward by the private sector is that there is no need to monitor individual consultants because this is done by the NHS. NHS Trusts may well know about consultants performing below par but, as noted above, consultants are not easy to dismiss. Neither does the NHS Trust release this information to the public at large. This difficulty of termination of contract in the NHS does not apply to the private sector. If the private sector is going to advertise itself as offering “the best standard of care”, then it should be prepared to back this up by removing admitting rights from under-performing consultants.

The inadequacy of the present approach is evidenced by a number of recently well-publicised incidents of consultants being negligent and causing great damage to patients both in the public and private sectors. In some of these cases it is now apparent that the consultants had been practising below standard for many years.

A proper system of medical audit combined with reactive complaints’ system could easily identify such sub-performing consultants. As discussed earlier, the patients’ expectation is that the private hospital company will only give admitting rights to those at the top of their profession. This, sadly, is a false premise created by inaccurate advertising in many cases.

In “*A Guide to Standards in Private Practice*” it states that: “All private medical practitioners must be registered with the General Medical Council (GMC) and observe its principles of good practice.” The GMC has set clear standards of competence, care and conduct for doctors. These are set out in Appendix I attached. However, in general it would appear that the private hospital companies do not enforce these standards vigorously and even when presented with clear evidence of a consultant not conforming to these standards are reluctant to act.

However, we recognise that poor consultants are the exception. Most consultants are responsible and caring and carry out their work effectively and to the best of their ability.

One must recognise that the possibility of human error will always exist. When it is you that is the patient that is damaged, or it is your relative that dies through substandard treatment, once is too often. Because of the nature of the industry, it is absolutely essential that every effort should be made to ensure that those carrying out the work are of the highest quality. This is not the case at the present time.

The medical profession has earned itself the reputation of maintaining a policy of “closed ranks”. Although within the NHS the consultant now has to be more answerable for his actions (although this is not a perfect system either), this is still not the case in the private sector. This approach has been allowed to continue to exist by the private hospital companies. However, it is not an attitude that is acceptable in today’s society and, for the genuine and caring consultant, and the patient alike, the best protection is an open and communicative complaints system.

At the present time, when there is dissatisfaction with the standards of care given by a consultant, the patient has no one to turn to, as the private hospital will claim that it is nothing to do with them. Accordingly, from the patient’s point of view there are needs to be outside intervention in the form of regulations insisting

4 March 1999][Continued

on a proper system of information and audit that can highlight substandard care. It would also ensure that advertising and PR is accurate in its representation of the situation and its description of relationships between the hospital, consultant and patient.

5.3 *The Current Position When a Patient Complains*

Many patients or relatives of patients experiencing unpleasant mistakes or “bad care” in hospital are reluctant to complain unless it results in a death or in long-term pain or disability. There remains a pervading ethos among some patients that they should not complain and that the doctor “knows best”. For others, they are merely desperate to put the whole experience behind them and believe that by complaining they will keep the incident at the forefront of their minds.

Thus it seems likely that many episodes of sub-standard care go by unnoticed and unreported.

In our experience, patients who actually do make the effort to complain about medical care are extremely distressed by their experiences. Their usual method of complaint is to write to the hospital that they, or their relative were admitted to.

In most private hospitals there is a Medical Advisory Committee, usually consisting of fellow consultants at the same hospital, that will look at the complaint. Given its makeup this committee is in no position to give an objective and independent opinion. Thus patients feel that their complaint has been “white-washed” and the inadequacies of the consultant go unchecked.

In most cases it would seem that the Medical Advisory Committee offers no discussion with the patient, no answers to the issues raised, no explanation and no apology. The impression given to the patient is one of arrogance and neglect of their interests on one hand and protection of those of the doctor on the other.

Very extreme complaints can be referred to the General Medical Council (GMC). They will look at cases of serious professional misconduct, which the GMC define as conduct which makes the GMC question whether a doctor should be allowed to continue to practise medicine without restriction. (They can also introduce penalties for poor performance, but it is not clear how many failures amount to “poor performance”).

Furthermore one must always bear in mind the enormous mental effort of it will takes for private individuals to continue to press their case against major professional bodies and organisations. The inevitable imbalance in access to professional resources and the time commitment required deter many people and therefore only in very extreme cases will people feel ready to take up the challenge.

Many serious complaints do not fall into the category of “serious professional conduct” (sometimes simply through lack of substantive evidence) and then there is no redress except to turn to litigation. For a bereaved or damaged patient, this is adding intolerable stress to an already desperate situation. For many elderly people, whose private insurance policies are one of their major financial outgoings, they will not wish to threaten their entire savings by taking on the might of the Medical Defence Union through the courts. They will be warned by their solicitor that this can sometimes cost hundreds of thousands of pounds.

5.4 COMPLAINTS PROCEDURES IN OTHER PROFESSIONS

For those consultants who work in private medicine, their occupation can in no way be construed as vocational. They earn high levels of remuneration and thus must be regarded as strictly professional.

It is interesting to consider other professions and see how they address complaints procedures:

Law Society

When a complaint against a solicitor is made to the Law Society, it is first investigated by the Office for the Supervision of Solicitors, to decide whether there is a case to answer. If there is, the case is then referred to the Compliance & Supervision Committee, which is the regulatory and disciplinary arm of the Law Society. This Compliance & Supervision Committee consists of 28 members, 11 of whom are lay.

In 1996 the Law Society conducted a major review of complaints procedures where the findings identified that it was vital to have significant lay participation.

Institute of Chartered Accountants

Any complaint referred to the Institute of Chartered Accountants about a chartered accountant is first sent to the Investigation Committee to ascertain whether there is a prima facie case. The Investigation Committee has no less than 14 members and at the present time has 20 members, 6 of whom are lay. If it is decided that there is a case to answer, it then goes to the Disciplinary Committee which sits as a panel of three, one of whom is lay with an Independent legal assessor to advise.

4 March 1999]

[Continued

There is a consultation paper out at the moment from the DTI, entitled "*A Framework of Independent Regulation for the Accountancy Profession*". The Minister of State, Ian McCartney, stated in the House of Commons on 17 June 1997 that the broad criteria to be applied to developing this framework would be "effectiveness, independence and transparency".

POLICE COMPLAINTS AUTHORITY

The whole of the Police Complaints Authority is civilian. The Home Secretary appoints the members of the Board and the rest of the staff are Civil Servants. None of them have a police background.

If there is a complaint, the local Force first investigates and then the case is passed to the PCA for impartial assessment. However, the PCA oversees.

Thus it can be seen that the other professions have gone to some length to make sure that complaints are impartially judged and that there is significant lay input to ensure that the conflict of interest issue can be seen to have been recognised and addressed.

The attitudes of these other professions contrast dramatically with the situation in the private healthcare industry at the present time. There can be no reason why private healthcare should not be brought into line with the standards in other sectors.

5.5 WHAT DO PATIENTS WANT FROM A COMPLAINTS SYSTEM?

When the Government conducted the exercise that led to the new NHS complaints procedures being introduced in 1996, they identified the following key objectives:

- Ease of access for patients and complainants.
- A simplified procedure, with common features for complaints about any services provided as part of the NHS.
- Improving the quality of service by acting on lessons learned.
- Fairness for staff and complainants alike.
- A more rapid, open procedure.
- An approach that is honest and thorough, with the prime aim of satisfying the concerns of the complainant.

These objectives are also relevant in the private healthcare system. Any complaints system needs to be easily accessible and easy to understand how to use. A patient needs to be able to complain by letter, by telephone or in person.

The private hospital needs to accept their duty of responsibility for what is carried out under their premises—this does not mean that they have to accept the blame. Rather that they are a "watchdog" that all consultants are carrying out their duties to the best of their ability and in line with the Code of Conduct laid down by the GMC (Appendix I).

Patients need to have their complaints fully answered and addressed so that similar incidents cannot occur again.

5.6 RECOMMENDATIONS

The private hospitals need to set out clear protocols for admittance and discharge procedures.

There needs to be a person designated in each private hospital to handle complaints and to be trained appropriately. That person will need to be able to explain the system and have a sympathetic and understanding approach to the patient.

To make sure that there is no conflict of interest, any person involved in the complaints evaluation should not be known personally to either the patient or the consultant.

Patients need to have their complaints fully answered and to have the ability to put "supplementary" questions.

Doctors and hospital staff should be prepared to apologise when appropriate.

Because it would be difficult for an individual private hospital to evaluate the effectiveness of a consultant in each specialty, an external system needs to be established which will evaluate clinical complaints which are unable to be dealt with at local level and also to receive complaints that are not resolved at local level.

The role of the Health Ombudsman needs to be increased to cover private medical complaints as well as those in the NHS. Although it is understood that this is outside the remit of the IHA, the Government needs to be lobbied to make this change.

4 March 1999]

[Continued

Although it is recognised that the private hospital companies do not actually employ the consultants, they do not have to grant them admitting rights. If the outcome of the complaint does find the consultant's performance to be "wanting" in any way, this then needs to be looked at and judged against the advertising of the private hospital. If, as is the case with many of the hospitals at present, the advertising is leading patients to assume that they are buying top quality care ("committed to excellence"), the admitting rights of the consultant should be withdrawn. In the less serious cases the consultant should be able to reapply after he has had re-training or is able to demonstrate a change in approach.

5.7 NEW PRIVATE SECTOR COMPLAINTS PROCEDURE

Any new complaints procedure should have the ability to incorporate the following:

1. The patient or complainant should be able to present their complaint by writing, telephoning or in person.
2. An identified person (the Complaints Officer) in the hospital company should respond promptly explaining complaints procedures.
3. The patient or complainant should be invited into the hospital to discuss their complaint.
4. The Complaints Officer should file a report clearly setting out the complaint.
5. If thought appropriate by the Complaints Officer, and desired by the patient or complainant, a meeting should be arranged between the complainant and the consultant complained about to see if any understanding could be reached. Where appropriate, consultants should be prepared to apologise.
6. If the patient or complainant is not satisfied, the complaint should be referred to a committee that should consist of at least three people that should include a member of the hospital company staff, a doctor and a lay person. None of these should be personally known to the consultant or the complainant.
7. The committee should interview both the consultant and the complainant.
8. The complainant should verbally be informed of any answers given by the consultant and should then be able to put further relevant questions that occur.
9. When it has been ascertained that the complaint is unable to be dealt with to the satisfaction of the complainant locally, it should be referred to an external Complaints Committee.
10. The role of the Health Service Ombudsman needs to be extended to cover the private sector.

5.8 CONCLUSIONS

The private hospitals need to make patient welfare their most important consideration.

Private hospitals need to take responsibility to make sure that consultants admitting to the hospital are ensuring that their patients are as well looked after as if they had entered a NHS hospital. They also need to ensure that consultants are operating in line with the advertising of the hospital.

A complaints system needs to be devised for patients entering private hospitals that is in line with current thinking in the other professional bodies.

APPENDIX 1

The GMC has set clear standards of competence, care and conduct for doctors:

- make the care of their patient their first concern
- treat every patient politely and considerately
- respect patients' dignity and privacy
- listen to patients and respect their views
- give patients information in a way they can understand
- respect the rights of patients to be fully involved in decisions about their care
- keep their professional knowledge and skills up to date
- recognise the limits of their professional competence
- be honest and trustworthy
- respect and protect confidential information
- make sure that their personal beliefs do not prejudice their patients' care
- act quickly to protect patients from risk if they have good reason to believe that they or a colleague may not be fit to practise

4 March 1999][Continued

- avoid abusing their position as a doctor
- work with colleagues in the ways that best serve patients' interests

GLOSSARY OF TERMS

GMC—General Medical Council

IHA—Independent Healthcare Association

NHS—National Health Service

DTI—Department of Trade & Industry

PCA—Police Complaints Authority

COMMENTS AND RECOMMENDATIONS

6.1 COMMENTS

Patients in private hospitals are regarded as customers, not as patients. Most are very happy with their treatment and cannot understand why others complain. They do not realise that victims of medical negligence or accidents are plunged into nightmare situations which many cannot deal with and which can drag on for years.

Everyone understands the grief suffered by those whose loved ones are killed or disabled in hospital. What is not appreciated is the after-effects that can destroy families in other ways when the hospital is in the private sector. Fury at the obduracy of the hospital management, who block attempts to obtain an explanation and an apology, is often combined with a cry of "Why didn't I insist that she went into a NHS hospital? This is compounded by the consultant taking refuge behind his medical defence society.

APROP members have suffered divorce and bankruptcy as a direct result of the family tragedy. Other families have been permanently split over whether the matter should be pursued or dropped. Such a disaster can happen in the public sector, but the complaints procedure, imperfect as it is, is incomparably more humane than what obtains in private hospitals.

In the private sector, priority is given to sweeping the matter under the carpet, to wearing down the complainants, hoping that they will give up and, as a last resort, agree to an out-of-court settlement, preferably with a gagging clause. The last thing private hospitals want is bad publicity. On the other hand, their insurers must have estimated that the large sums they have to pay in compensation to victims of medical accidents is much less than the sums required to staff and equip their hospitals to the higher standards required.

6.2 RECOMMENDATIONS

6.21 Legislation

As stated earlier in the memorandum, problems in the private sector can largely be solved by including private hospitals in the plans for the NHS published by the DOH in its Command Paper 3807 published in December 1997 and entitled "A First Class Service".

This is a strategic document, setting out the Government's plans for improving the Health Service over the next 10 years. Some legislation is needed now however, to protect private patients. Private hospitals must be made responsible for all aspects of their patients' welfare. This implies that consultants could no longer work as independent contractors, but as employees, as they are in the NHS. The hospitals should be effectively supervised, inspected (including clinical audit) and controlled. A statutory complaints procedure should be imposed, including an Independent Review Panel and access to the Ombudsman. The hospitals should be obliged to publish accurate data on clinical matters, and promotional literature that is not misleading.

4 March 1999]

[Continued

6.22 *A First Class Service*

As the different provisions of this plan come on stream they should include the private sector. All the current deficiencies of private hospitals are covered by them.

6.23 *The Commission for Health Improvement (CHI)*

This ensures that the highest clinical standards are met and that hospitals are properly staffed and equipped to safely undertake the medical and surgical procedures they perform. At present no such controls exist.

6.24 *The National Performance Framework (NPF)*

The NPF will measure what is really important for the patient's welfare, their clinical care. It will also compare results in the same specialties in different hospitals. Currently not even the incidence of perioperative deaths is published. Only the management know the essential data covering the clinical performance of the hospital.

6.25 *The National Institute of Clinical Excellence (NICE)*

The remit of this Institute, working with the CHI, is to develop best clinical practice. Its membership will be drawn from a variety of professional sources and PATIENT INTERESTS. No patient representation is known of throughout the private sector.

6.26 *Lifelong Training*

Staff must be involved in lifelong training. When this comes into effect consultants will be included if employed by the NHS. This leaves the problem of nurses' training. They need more training than NHS staff as they are "generalists", expected to cover most specialties.

Much more could be said about "A First Class Service" but it seems obvious from the above few references, to an 86 page document, that, when implemented, the framework will be in place to bring private hospitals up to standard.

Obviously the question of cost arises. The infrastructure would be there, few extra staff would be needed as the number of hospitals involved is a small proportion of those in the NHS and the extra cost should therefore not be great. Private hospitals already pay fees towards the cost of ineffectual AHA inspections. These fees could be raised. Hospitals also pay for inspections carried out by organisations such as the King's Fund and later boast in their literature about being "accredited", omitting to mention that the audit is purely on organisational matters and has little to do with the clinical care of the patient. Presumably such audits would not be necessary when under the scrutiny of the First Class Service and its charges could be re-allocated.

That concludes APROP's memorandum. We hope that the Health Committee agrees with us that the present lack of control in the private healthcare industry is intolerable and that action is necessary to protect its patients. Thank you for asking us to submit evidence.

January 1999

Memorandum by Mr Graham Maloney, APROP**PRIVATE HEALTH CARE (PM 19)**

1. Private Health Care—Failure to Diagnose Breast Cancer.
2. Private Health Complaints Procedures.

This is an outline of what I have had to do to have my complaints heard about the less than satisfactory treatment and the complaints procedure tested in private health care.

It has been especially difficult for me because there were two complaints. The first one about the failure of my late wife's surgeons failure to diagnose breast cancer. The second complaint was about the lack of care at the private hospital when my wife was dying from this cancer.

*4 March 1999]**[Continued]*

1. FAILURE TO DIAGNOSE BREAST CANCER

As a family we took out private medical insurance after reading private hospital brochures believing it to be the best care we could buy to help with our health management.

My wife Christine was referred to a general surgeon with a problem lump on her breast. The surgeon diagnosed a benign disorder after several tests. That benign disorder turned out to be cancer of the breast which was diagnosed by a different surgeon via the NHS (approximately 14 months later). Christine and I wanted to know why her cancer was not diagnosed in the 14 months she sought help privately.

1.1 See Christine's letter to Mr Peel, Consultant Surgeon, dated 2 July 1992 enclosed¹⁵.

1.2 See Mr Peels reply dated 16 July 1992.

1.3 Our concern about two false negative diagnosis provided by a mammogram and a fine needle cytology was understood by Professor Norman Browse of the Royal College of Surgeons. See his letter to T Devlin MP dated 24th January 1994.

In trying to get answers to my questions I asked to see the surgeon Christine saw privately. He refused this request.

The cytology test the same surgeon carried out on Christine to help with the correct diagnosis took five and a half weeks to reach my wife. Although the consultant surgeon described the test result as very satisfactory Professor Michael Baum of the Royal Marsden Hospital described the same cytology and its report as inadequate for diagnostic purposes.

1.4 See Professor Baum report dated 8 September 1994 and 26 January 1995.

I was amazed to find that there were no statutory complaints procedure to help me to find out what went wrong in Christine's private care. The only real option open to me was to spend large amounts of money on legal fees which I have done. Diagram 1 shows a comparison of statutory complaints procedures and guide lines in the NHS compared to that available for private patients.

2. PRIVATE HEALTH COMPLAINTS PROCEDURES AND LACK OF CARE

In October 1993 Christine was in the Nuffield Hospital, Stockton-on-Tees for pain control. As things were going badly at that time she asked her Oncologist how long she had to live. After consultation with myself, Christine was informed that she had approximately six weeks to live. The Oncologist and myself knew that this was the information that she wanted. After asking if the Nuffield Hospital could cope with a terminally ill patient's pain control and being informed that they could, Christine arranged her own funeral from the hospital bed. She elected to stay in the hospital for her final days.

On the night/morning Christine died, I had to ask for pain control drugs to be administered on more than one occasion. I was so concerned I rang the Oncologist to ask for help. He said he would speak to the Sister in charge and asked her to give more support to Christine. That support was not forthcoming and when Christine died at 5:45 am I could not find any members of staff and again had to ring the Oncologist and report her death. He recorded this time and it was over an hour before anyone came in attendance. After I informed a member of staff that Christine had died the RMO was called and he confirmed the time of death at 7:00 am. This therefore shows that the Oncologist, who lived 40 miles away, was aware of Christine's death for over an hour before the person in charge of the hospital.

I complained to the matron about the lack of care, she informed me that she would hold an internal investigation. She did not however, tell me of my right to take my complaint to the Registering Authority. I also wrote to the Nuffield Hospitals chief executive, highlighting my complaint. He also failed to tell me of my right to take my complaint to the RA. It was nearly two years later I discovered my full rights to approach the Registering Authority, this information was given to me by Lord Wolf.

The first investigation carried out by Tees Health Authority into my complaint was totally inadequate and unacceptable.

1.5 See copy dated 20 November 1995.

There was a review of the first investigation where I was given an apology about the first inadequate investigation.

1.6 See copy dated 14 June 1996.

I knew that the lack of care was more serious than what had been investigated so for the safety of future patients I pursued a second investigation by lobbying two MP's and writing over 50 letters of correspondence. My concerns were proven to be correct and a second investigation was carried out. The result was a 35 page

¹⁵ Enclosures not printed.

4 March 1999]

[Continued

report from Tees Health Authority making serious recommendations to the Nuffield Hospital. One of the main conclusions was that the stock control and invoicing of drug usage and recording of such was open to error and therefore unreliable.

1.7 See full copy of Tees Health Authority second report concerning C Maloney.

My complaint has taken two investigations and one review, the last investigation taking nine months. Tees Health Authority subsequently recommended that an agreement between the Health Authority and the Cleveland Nuffield be made, detailing the steps to be taken in the situation of a complaint being made by a private patient. This request was turned down by the Nuffield Hospital Groups Company Secretary.

1.8 See letter dated 8 December 1997, Nuffield Hospital to Tees Health Authority.

Private hospitals by law have to be inspected at least twice a year by the Registering Authority in order to protect patients using those facilities. I have copies of inspection reports concerning the Cleveland Nuffield dated from 1993. At least two inspections lasted only 45 minutes and one unannounced inspection did nothing more than check the quality of food, cleanness of the hospital and the lighting. It has to be said that if it has taken two investigations and one review, the last investigation taking over nine months, what is hoped to be achieved in a 45 minute inspection checking the hotel side of the hospital (not a lot).

1.9 See two copies of the Nuffield Hospital inspections by the Tees Health Registering Authority.

Members of the public who have taken out private medical insurance also pay for their NHS entitlement, in effect paying twice for their health care. It is totally unacceptable that after being sold the so called Rolls Royce of healthcare there is no statutory complaints procedure when things go wrong. It is also wrong that Consultants working privately are fully insured against litigation, as are the hospitals. The most important people, the patients, cannot take insurance out against an accident in a private hospital. This creates an uneven playing field.

Private patients should have at least equal statutory rights to that available to NHS patients. Anything less is totally unacceptable.

My other concern is that when health authorities purchase beds from the private sector for use by NHS patients, those patients are protected by the guidelines and statutory complaints procedures available in the NHS.

January 1999

Annex

Comparison of Guidelines and Complaints Procedures in the NHS and Private Sector

	<i>NHS Hospitals</i>	<i>Private Hospitals</i>
Patients charter	YES	NO
Community health council	YES	NO
Statutory complaints procedure	YES	NO
Independent review panel	YES	NO
First and second opinion with above	YES	NO
Access to Health Ombudsman	YES	NO
Six month guideline for completing all of the above	YES	NO

4 March 1999]

[Continued

Examination of Witnesses

MR JOHN LAMBIE, Retired Businessman, Founder Committee Member and Chairman, MRS CAROLINE BUCKLEY, Housewife and former nurse, MS SAMANTHA RYB, Barrister, MR GRAHAM MALONEY, Businessman, Action for the Proper Regulation of Private Hospitals, APROP, MR ARNOLD SIMANOWITZ, Chief Executive, MS LIZ THOMAS, Assistant Director and DR JULIA HINES, Caseworker, Action for Victims of Medical Accidents, AVMA, examined.

Chairman

207. Can I begin by apologising for the cramped conditions and again express my appreciation to the witnesses for being willing to come along to speak to us today, and in particular for the very thorough and detailed written evidence we have received from you. I do appreciate that some of you have provided us with some obviously very painful information from your own personal experiences and we appreciate the fact you have shared those experiences with our Committee. That information is very helpful to us in this inquiry. Could I begin by asking you all briefly to introduce yourselves to the Committee, what you do in your organisation, a bit about your organisation before we ask questions?

(*Dr Hines*) My name is Julia Hines and I am a medical case worker at Action for Victims of Medical Accidents. I do not actually practice as a doctor any more.

208. Just for interest, are you a medical doctor?

(*Dr Hines*) I trained as a medical doctor, I am not registered with the GMC any more and I have not worked in that sphere since 1994.

(*Ms Thomas*) Liz Thomas from Action for Victims of Medical Accidents. I am Assistant Director of Client Services there and I have been working for them for the past ten years initially on the case work side. That service is provided to the general public for anybody who thinks they may have been harmed or injured as a result of medical treatment, and we offer a free advice service to people. Often they are just looking for an explanation for what has happened to them, but we also talk to them about the various options whether it be complaining or taking legal action.

(*Mr Simanowitz*) I am Arnold Simanowitz and I am Chief Executive of Action for Victims of Medical Accidents. This is an organisation that was set up about 16 years ago as a charity. It arose in fact as a result of a television play and what we are concerned about most is standards because medical accidents arise as a result of a lapse in standards, and although we have quite a high profile in the legal field our main interest is in standards and in something which has not come up very much in the earlier evidence, accountability. The essence of the problem is accountability and in the early years we were concerned almost entirely with the NHS but the problems in the independent sector have sneaked up on us. We were worried about accountability in the NHS and gradually that has improved, all the time there are new moves in order to improve that accountability, but there has not been anything similar in the independent sector and that is our concern.

209. So you are a voluntary organisation and a charity basically?

(*Mr Simanowitz*) Yes, we are.

(*Mr Lambie*) My name is John Lambie, I am the Chairman of APROP, Action for the Proper Regulation of Patients in Private Hospitals. This is our sole concern and we are perhaps unique in facing you today as the only group who have personally experienced the deficiencies of the private sector and we are determined, I hope through your good offices, to reach the Government and persuade them to introduce new legislation to properly control private acute hospitals and to protect the patients. An absolutely vital need at this stage.

(*Mrs Buckley*) My name is Caroline Buckley, I am a co-founder of APROP. My mother, Carole Burwash, the grandmother of my four children, was killed in 1995, aged 53, at the private Princess Grace Hospital in London by what the inquest coroner called "a catalogue of medical errors".

210. I think it may well be that we will come to you in a minute to ask you about your personal experience, because I think it is very important we hear those personal experiences. Thank you for introducing yourself and we will come back to you in a moment or two.

(*Ms Ryb*) My name is Samantha Ryb, I am a barrister, and I am also a co-founder of APROP. My father, George Ryb, died at the London Bridge Private Hospital in 1990 as a result of negligent treatment afforded him by the consultant responsible for his care and he was 53 years old. As a result of legal action against the consultant my family received an out-of-court settlement some seven years later, however there was no apology or admission of liability. Can I take this opportunity of thanking the Committee for giving me an opportunity to speak today.

(*Mr Maloney*) Graham Maloney, founder member of APROP. My wife put her trust in a private hospital and got misdiagnosed with a breast cancer twice, there were two false negative results within six months, and also during her last two days in that hospital where she elected to die there was absolutely appalling care. We all got together nine months ago to form this group because there is no other association to represent the real problems of patients. We have only been going nine months and we have 150 to 160 members already.

211. Can I begin by asking the same question I asked the first group of witnesses? Certainly most of you, if not all of you, were here to hear the question. In a sense, it is asking you to tell us about the problems you have touched on already, which you have encountered with the private sector. We are particularly interested in your organisation, Mr Lambie, so perhaps you can begin by giving us more detail about your very tragic circumstances, and I am sure you will appreciate that sharing those with us will be helpful for the inquiry.

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Chairman Cont]

(Mr Lambie) Of course, Chairman. I suppose the most appropriate thing for me to do is not perhaps dwell on my late wife's case but to explain to the Committee what happens when you go into a private hospital and some untoward event or medical accident occurs. Dr Brand earlier raised this question of the relationship between the patient, the hospital and the consultants, and this is quite unique. One of my overseas friends when I explained the situation said, "This is Alice in Wonderland stuff". You go into a private hospital having read brochures which misrepresent the situation very badly, they are masterly from the point of view of public relations but most inadequate from the point of informing the patient. When you go in, you are assured that you will have a private room, you will see the consultant very quickly, have your first consultation and an operation, for instance, very quickly, you will be seen by the consultant only, he is in sole medical charge of you. This situation is quite frankly deceiving the patient. The one thing that is accurate and true is that you go in and you have your consultation and your operation or procedure, whatever, that is absolutely true. The second one is that you have a private room, and that is accurate, but of course the patient does not realise that that private room can be a death trap. If the patient is in real trouble and cannot reach an alarm button, or in the case of one of our members where the alarm button was removed because the teenage boy was considered to be crying wolf and subsequently found to have a tumour on the spine, there are consequences, and we have on my right Mrs Buckley whose mother would not have died had she been properly monitored in a public ward in a public hospital. The other thing seems so self-obvious it is unbelievable and people like us and no doubt you would not think of it, the consultant is normally, most often, a consultant in the NHS and probably has admitting rights in other private hospitals, and consequently you see the consultant about five minutes a day and for the rest of the time you are in the hands of a comparatively inexperienced RMO. You then find when something goes wrong that you have a contract with the hospital, the hospital has no contract with the consultants, they are independent and they are not controlled or supervised in their clinical work by the hospital. That is absolutely clear when anything wrong happens. The next thing is that you have a "contract" with the consultant. When a clinical disaster happens, you find the hospital says, "Nothing to do with us, it is him or her".

212. They are an independent contractor basically?

(Mr Lambie) Absolutely, independent contractors. No allegiance to the hospital, they rent premises, offices, theatres and so on, but they do not have any obligation to the hospital.

213. Mrs Buckley, would you like to follow on? You were starting to refer to your own experiences. If you could be reasonably concise because I am trying to hear everybody in a fairly tight session.

(Mrs Buckley) Briefly, my mother would be here today if she had been on the NHS and not in a private hospital. I actually trained in London as a nurse and prior to having my family was a nurse. She went in for a routine hysterectomy and the anaesthetist decided to give her an epidural as her pain relief. He

decided to use diamorphine which is a very well known opiate but also a very difficult drug to use in that way in that it is unpredictable. The anaesthetist, as in a lot of hospitals in the independent sector, was not working within a team environment, he did not meet the RMO who was in charge of the hospital that night. As with a lot of the independent sector one RMO covered the entire hospital overnight and this RMO was in charge of 100 patients. He did not have the expertise to understand what he was doing and he was presented with an epidural opiate. She was placed in a side room at the end of a corridor on a ward which did not specialise in anything particularly. That again is one of the private systems assets, if you like, because you are in a private room with your own bathroom, et cetera. The nurses were unfamiliar with any procedures. The doctor misread the drugs chart and instead of putting 3 mg in he put 30 mg in. The nurses were not looking after her, they did not do the observations which were required, she probably would have been in intensive care had she been in the NHS. They found her too late, they bungled the resuscitation because he was the only RMO. The same doctor who had given the overdose was also in charge of the resuscitation. They did resuscitate her, she was put in their intensive care unit and then immediately transferred in a coma to the local NHS hospital where she was for three days and then we had to turn her life support machine off on the Saturday although we did actually donate all her organs. The clinical care received by her was totally inadequate, mainly from the lack of expertise the doctors had. Within the NHS that simply would not have happened. I have been that private nurse and I have been that NHS nurse and I know it would not have happened on my ward, which probably sounds rather egotistical but it would not have done because you are within a team. The consultant goes in, he rents his operating theatre, he rents his room, he does his operations and off he goes and he leaves it in the care of the RMO, and unless those RMOs are adequately trained every single patient is at risk in that hospital overnight. There is a three-day course, the ACLS, advanced course in life saving, and every single RMO in charge of a hospital overnight should have that and currently that is not a statutory procedure; nobody has to do that.

214. Could I ask why your mother chose, or you chose for her, to go into the private sector? Was it that she could get quicker access to the operation she needed? Presumably she was seen by the NHS as requiring a hysterectomy?

(Mrs Buckley) It was basically chronic menopausal problems which lots of women have, a GP referral to a consultant, my father and my mother believed the private sector was best. I was actually very against them going privately but you see the brochures, as most lay people do, the thick carpets, the wine list, the food list, the catering facilities, the private ensuite facilities, you immediately assume that the doctors are obviously better than the NHS and that is why they went privately.

(Ms Ryb) My father also died in a private hospital, as I have mentioned, and certainly I believe had he been treated in a NHS hospital he would be here today. Essentially my father died because of lack of proper back-up facilities. My father was admitted to

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Chairman Cont]

the London Bridge Private Hospital in April 1990 for a procedure known as angioplasty, which is a procedure which unblocks narrowed arteries around the heart. It was described by the referring consultant as "a Hoover job", as a very minor procedure. He was admitted for what was meant to be two nights. He was told by the consultant in a letter—he had not actually seen the consultant who was performing the procedure prior to the treatment actually being performed—that during such procedures it was usual practice to have a cardiac surgeon and anaesthetist standing by just in case an artery were to block after the angioplasty and an emergency by-pass was necessary. He was told in this letter that this would be arranged for a fee of £300. We were not told prior to the procedure who the cardiac surgeon or the anaesthetist were going to be. My father met the consultant who performed the procedure on the morning of the procedure itself, my father went down for what was going to be about an hour and a half, the consultant came up to see my mother a couple of hours later to say there had been a problem, that when they were bringing him up one of the arteries had narrowed but not to worry they had a particular surgeon there and he had been transferred to theatre and an emergency by-pass was being performed, to be patient and the surgeon would be up to see her later. She never saw the surgeon and neither did I, and I had come back to the hospital by this time. We never saw the consultant again. We were informed at about half past four in the afternoon by an administrator and the anaesthetist that my father had died. We were given no information, no sympathy, we were not advised of any complaints procedure, anywhere we could turn for further information.

215. So you were informed by the anaesthetist and an administrator?

(Ms Ryb) That is right.

216. Not by the consultant in charge of his circumstances?

(Ms Ryb) No, we were not. The only contact we had from either the consultant cardiologist or the surgeon was a few days later when we received their bills. That was it. In fact the surgeon had addressed his bill to my father. I took it upon myself to go and visit the cardiac surgeon in his private consulting room some weeks later to discover that he had not been standing by at the private hospital at all, he had been operating in the nearest NHS hospital, and he said, "I did the very best I could but by the time I got there it was too late. By the time we opened the chest there was too much damage and it was very fortunate that we were able to find an anaesthetist who just happened to be visiting a friend in the hospital", he actually worked at Harefield Hospital. After that, we had a great deal of very, very conflicting correspondence from the surgeon, from the Medical Defence Union, from the hospital. It was against that catalogue of conflicting statements that we consulted experts and we were basically told that it was a very dangerous procedure to perform on my father in the first place, although our expert recognised that some doctors would perform it, but he said it was absolutely imperative that the cardiac surgeon and the anaesthetist were in immediate proximity and ready for instant action. Obviously we believe had

they been there, my father would have survived. The only avenue open to us at that time that we were advised of was to litigate in an attempt to find out what had happened. Because private hospitals are not responsible for the consultants who operate within them, we had no come-back against the hospital, we had to sue the consultant. Fortunately we qualified for legal aid, which is how we managed to pursue the claim, however, it took seven years, it was very, very draining. Both my paternal grandparents who were alive at the time died during that time. A lot of the legal tests and burdens which are imposed are very artificial and onerous, they do not bear any relation to ascertaining the facts and getting any kind of accountability or justice. At the end of the day, as I said, we received no apology, there was no admission of liability and we still to this day do not know what actually happened, we really do not know what actually happened. There have been conflicting statements from the hospital which in 1992 said they did not feel it necessary to have a full enquiry into my father's death, yesterday they told a newspaper that in fact the matter had been investigated very thoroughly. Well, if it was, we certainly did not hear anything about it.

217. This might seem an irrelevant question but you are a lawyer and you mentioned the case you took subsequent to your father's unfortunate death was based on legal aid. Would you now, with the current proposals in respect to changes to the legal aid system, be able to take that action?

(Ms Ryb) When we were on legal aid it was some six years ago and I was not a lawyer, I was a student at that time—

218. But in the same circumstances, if those circumstances applied to the future arrangements which are now proposed, how would they affect your situation?

(Ms Ryb) It would make it very difficult. In fact during the progress of the litigation the legal aid rules changed, and it would have made it very difficult even two or three years on for us to qualify for legal aid. We would not under the new proposals qualify for legal aid, we would not be able to finance the action ourselves.

Dr Brand

219. Can I ask a question of clarification, Ms Ryb? Did you say that your father was given an option to have this procedure performed without the cardiac surgeon standing by and the anaesthetist, the option for an extra £300 to have them standing by? Is that what you were saying?

(Ms Ryb) It was not an option. In the letter the way it was phrased was that it was usual practice to have a cardiac surgeon and an anaesthetist standing by and this will be arranged.

220. At an extra cost?

(Ms Ryb) At an extra cost of £300.

221. Which he was not aware of when he first went in?

(Ms Ryb) This letter preceded his being admitted to hospital, so, yes, he was a few days earlier.

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

Mr Gunnell

222. Was he charged for it on the bill you subsequently received?

(*Ms Ryb*) They actually did not. Because the emergency by-pass had been performed we received separate bills from the cardiac surgeon and from the consultant cardiologist who performed the angioplasty, and a separate bill from the hospital.

Dr Brand

223. It is, of course, extremely difficult, Mr Chairman. Some angioplasty specialists will do it in portable units in hospital car parks without any cardio-thoracic back-up at all, and this is where the debate comes in. I was interested to see you almost got offered an option of extra safety, which strikes me as irresponsible.

(*Ms Ryb*) Part of our legal action was based on lack of informed consent because our expert actually said that he personally would not have performed this procedure on my father.

224. On him?

(*Ms Ryb*) On him, yes.

Chairman

225. Mr Maloney, would you like to tell us about your experiences?

(*Mr Maloney*) I am from the North East, and as a family with two boys at university, my wife was an accountant, all the bills go into one hat but we could afford to take out private medical insurance. We read the brochures and believed how wonderful it was. It was always at the back of my wife's mind, having a history of breast cancer in the family, that it would be wonderful if she found anything to go and see a specialist consultant. She did find a lump in 1991, she went to her GP who referred her to a private hospital in the North East. She also took with her the complete history of the family tree, the cancer, one thing and another, and asked the consultant surgeon if he could identify the diagnosis. She thought it would be good because it was a one-to-one consultation, there was no time limit, and all the latest technology was available. He carried out a mammogram and an ultrasound and diagnosed mastitis. We all know that mammograms are not as sensitive for young ladies but the problems persisted and six months later she referred herself back to the same consultant privately. The lump had got bigger and obviously she was concerned and so was the surgeon because he carried out what they call fine-needle aspiration cytology. My suspicions started then because it was six weeks before she got the results back. To be honest, if you employed a plumber and you waited six weeks, you would get rid of him, so in private health care I had my suspicions. The letter came with an apology for the delay but it also said he was very delighted with the result and to carry on with what they call Evening Primrose oil to alleviate the pain. To cut it down, she suffered with pain, discomfort but put it down to the diagnosis she had. Four months after that she had a further consultation, again in the same private hospital. In most families now everybody works, you get on with your life but she went back for a consultation where

he did a physical examination. Two weeks after that she was suffering from pains in her thigh, no connection at this time. The local GP, who we know anyway, said that she had had a fall from her horse, probably strained herself, come back in a couple of weeks if it persisted and he would send her to the National Health for an x-ray. That happened and the x-ray discovered that she had cancer of the thigh which turned out to be secondaries. We told the consultant orthopaedic surgeon at the time, a very fine man, "We can tell you where the primary site is, it is the breast."

226. That was in the NHS, was it?

(*Mr Maloney*) Yes, this is the National Health. They were fantastic, they really were, within two days they had diagnosed Christine. They were not interested in the fact we had a policy. That was Mr David Miller, a wonderful guy. Of course, Christine, the type of person she was, was not interested so much in litigation, but it was said in the National Health Hospital, "Mistakes have been made, why do you say it is the breast?", "Because that is where the pain and suffering is, that is what I have had consultations about for over 12 months". Tests confirmed it was the primary site. Mr David Miller, Consultant Orthopaedic Surgeon, said that although he would like to keep in touch, he referred her to an oncologist, Dr Brian Cantwell, Consultant Medical Oncologist. Christine, the type of person she was, was concerned for future patients and wrote to the surgeon and said, "I am concerned for future patients. I followed the recommended path to early detection. I believe we have the worst record in the Western World"—I am sorry.

227. It is okay. Shall we come back to you later?

(*Mr Maloney*) Yes, please.

228. Dr Hines, you do the case work side of your organisation. How do you respond to the experiences that you have heard about here and from the earlier witnesses? Is this the same kind of picture you are seeing in the work you do?

(*Dr Hines*) Yes, very much. We hear the same stories over and over again. AVMA has helped over 25,000 clients since we started. Quite a number of those do come from the private sector now, although we cannot put an exact figure on what proportion it is, and we do see the same problems. The same problems of who is in charge, having an RMO who is not necessarily a physician or a surgeon, who is having to deal with all different kinds of specialities overnight, who is not invited to attend the ward rounds, who does not get formal handovers from the consultants, who is only there to cover. The consultant provides the primary care and the consultant does not really want the RMO involved. He is therefore not being trained, not being mentored, is not really involved with those patients' well-being, and is doing it to fill in between studying, to take exams, rather than for other reasons and so does not have a personal stake in the care of the patients.

229. Do either of your colleagues want to add to this point?

(*Mr Simanowitz*) We hear these stories, very moving stories, I am sure the Committee are very moved by it and you can imagine how harrowing it is for our case workers, to see the same thing replicated

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Chairman Cont]

20,000 times. These are not isolated instances. Most of those cases are obviously in the NHS but there is the additional problem that arises in the independent area and it is becoming more and more prevalent, it is becoming more obvious to us that these are the issues, the RMO's lack of qualifications, the lack of accountability of the surgeons, the doctors, who are operating, and the big problem which was touched on in the earlier sessions and again now is who is accountable when it goes wrong, the passing of the buck from one to the other. So there are two aspects to this. There is that side, there is the care, and then there is the redress, not in terms of litigation. I am sure the Committee will be absolutely appalled at the idea that people should be driven into litigation to get answers. There is a third aspect and that is the advertising of the care. If one message could go out from this room, it is that independent care does not necessarily mean better care.

(*Ms Thomas*) Certainly on the issue of getting redress, I have been helping a family for the past two years whose son died in a private hospital. It was quite clear straight away what had gone wrong but two years down the line they are still no nearer getting any public acknowledgement of what happened. They tried the Health Authority route and getting them involved as to what happened but that is really taking them nowhere at all. They are getting to the point shortly where they may be having to sue, which is the last thing they want to do. In effect the claim is worth no money because they would have to pay out of their pockets in order to do that and that is not the answer for them, they want someone to acknowledge what has happened and put things right within that hospital.

230. Can I bring Mr Maloney back now?

(*Mr Maloney*) Thank you, Chairman, I am okay now. I will try and keep this as short as I can. Basically Christine went to see the surgeon, she was concerned for future patients. I thought I was getting the best. I was not interested in litigation. He said he had done everything he could, it is very difficult for pre-menopausal women, we all know that. The most important thing at that time was to look after Christine and look after the secondary cancer. Unfortunately she died in November 1993 because she had quite a progressive disease. Because she was concerned for future patients I thought I had to do something about it so I wrote to ask to see the surgeon. He has got a good name, he is well-respected in the area, he is actually one of the leading surgeons in the breast screening programme in North Tees. I went to the House of Commons with the launch of the National Cancer Alliance and all the girls then from MacMillan Nurses were very concerned because we do have the worst record in the Western World and this type of thing has to contribute to it. So then I found out the test that he was highly delighted about was totally inadequate for diagnostic purposes not on one count but two. I wanted to ask the question, "Why do you think Christine was not entitled to a test of diagnostic value" but I cannot ask him that because he will not see me, which is fair enough, but then you think you are getting the best care and you are not and you have medical insurance. An insurance policy for me works when things go wrong as well as when things go right. You can get

third party insurance, fully comprehensive insurance on a car, and insure yourself against accidents, you can insure yourself in the home, but you cannot insure yourself for accidents in a hospital. It is a nonsense, it is a lunacy, it is like something out of Alice in Wonderland. Reading the brochures from other hospital groups, BUPA, Nuffield, they are full of mistruths, it is a con. It is a con because it deliberately deceives the public and does not give the public enough information to make the correct analysis and decision. The complaints procedure—I was amazed there was no complaints procedure in private health. I have said this to Tees Health Authority, who got there in the end. I have had two investigations and one review, and I must admit that was using the help of parliamentarians, and of course I can only thank Dari Taylor that we are here today. She is my MP, one of Mr Blair's babes, and my God she lives up to that! When I went to Tees Health Authority and said, "We have a young lady here who has died of cancer, the tests were inadequate for diagnostic purposes", they said, "We cannot get involved with that. That is a separate contract." I said, "I'll have to sort that out myself. Are there any complaints procedures because when Christine was dying in the hospital I was the one who laid the body out?" The same hospital. The matron said there was nothing she could do, there is no complaints procedure. I had limited funds but I thought I have to try and find out, because I cannot go sounding off what was not correct and what was, so I met Carol Sikora an excellent man from Hammersmith Hospital, Mr Charles Coombes, a brilliant oncologist, from Charing Cross Hospital, I showed him the tests and he confirmed what I am saying is right, shaking his head, "Scandalous, why didn't they repeat the test?" Everyone said that. Christine went to the Cladland Nuffield Hospital for help, they could not have got a better patient, she gave them all her history and yet the FNAC test was not adequate on both counts. Blood stained smears and no cells. Then, of course, I thought I ought to try and make some good out of this. We got to the stage where Christine wrote to the surgeon and so she could get a reply the bottom line said, "Please note no legal action is implicated".

231. We have seen the correspondence, you have very kindly given that to us. I have studied it and I am most grateful you have shared that with us because it is most helpful for us to be aware of that.

(*Mr Maloney*) We could get round that legally but morally I could not because I know the type of person Christine was. The total bill for Christine's care was approximately £48,000. I had laid the body out myself, and that is confirmed because on the night Christine was dying (she elected to die in the Nuffield Hospital because she was on a catalogue of pills) they could not cope and I could not. It was just appalling nursing care—well, Florence Nightingale would have turned in her grave. It was two years down the line and I had attended a conference at AVMA's invitation and Lord Wolf was present—Late September 1995 I think it was—and I attended this meeting in London at the North London Voluntary Resource Centre. Lord Wolf met me at lunchtime and I said, "I know you are only looking at the complaints procedure in the National Health

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Chairman Cont]

and up-dating the Patients Charter and the Health Ombudsman, but why is there not a complaints procedure for private health", and Lord Wolf, the gentleman he is, said, "There is a complaints procedure in the Registered Homes Act and they can look at a complaint about care", but of course I had been lied to by the matron, by the hospital manager, by Mr Irving, the chief executive of the Nuffield Group. I wrote to him pointing this out and he wrote back saying, "Condolences but there is nothing else I can add." I wrote back and said, "At a bill of £48,000 at least you should have the decency to tell me I could have complained to the regulating authority." So then I went to the Health Authority two years ago and told them I had to lay the body out, the oncologist can confirm that, and on the night I had to plead for drugs, I had to treat that patient myself, and I was so concerned at 12 o'clock I rang the oncologist in Newcastle, 40 miles away, and he said he would ring the person in charge of the hospital because I was in the room attending the patient. You would get better care on a market stall. Christine died at 5.45 and it is more obvious than in the films. I walked up and down the corridor, couldn't see anybody, I got a mirror out, I got a stethoscope out, a private hospital, I thought I had better tell somebody so I got back on the phone and rang Dr Cantwell and luckily enough he recorded the first telephone call and he asked me, "Has it improved?" I said, "No they do not even know, she is dead." At the end of the day, Dr Cantwell advised me to try and find some other staff. He recorded the time of death and I sat down, I was in a trance, just gutted, and then I thought, "I want my wife as presentable when she is dead as when she is alive", you are still in love with the person, so I laid the body out, so to speak. When I complained to Tees Health Authority, finally two years after that, the report was a page and a half.

232. Two years after?

(Mr Maloney) Two years. I threw it back at them with the greatest of respect. I went to see Tees Health Authority again and I explained that there was a young lady in there on dangerous drugs, everyone knew she was dying of cancer, told them to speak to Dr Cantwell, I had laid the body out, it was a disgrace and, further more, there was no safe practice on the drugs because I was pleading for drugs to be given. Drugs were given and not recorded, recorded and not given. So after seeing two MPS who wrote on my behalf—Frank Cook, brilliant, although I am not in his constituency, he said to me, "Well the hospital is", and I explained to him the situation—we got a second report which is being used in other legal cases, it is unprecedented, it is the unofficial guideline as to what private patients should expect when a health authority decides to investigate a complaint. Some health authorities will follow this, as AVMA will confirm there are one or two cases there, but the Nuffield Hospital fought this and lost and this report was produced. But I have to say to this Committee now the only reason I got this report is because on leaving the hospital that morning I took with me the drugs prescribing chart and ward consumable charge sheet and you cannot expect patients to do that, but me being a street-wise scouse and all the rest, I thought, "Right, I am going to need some proof here." Then I got a friend of mine to give me a copy

of the final bill from the Nuffield Hospital and I married it to this. There are nurses in my family and we found discrepancies. With the discrepancies I went back to Tees Health Authority and said, "If you go into a chemist and buy a box of aspirin there is a warning on there, 'Keep out of the reach of children, don't exceed the amount', there was a young lady there, on dangerous drugs, dying of cancer and they disregard the drugs administration procedures." It was so important that Tees Health Authority severely reprimanded the hospital saying that the drugs administration and storage was potentially dangerous, unreliable and open to error.

233. So you felt the Health Authority took the issue seriously? It took a long time but they did?

(Mr Maloney) When I produced this. The drug prescribing and ward consumable charge sheet.

234. When you produced the evidence?

(Mr Maloney) Yes, when I produced this. The important thing is that you know with hospitals providing private health there should be two things: the service you get and also a statutory complaints procedure. The complaints procedure is a nonsense, a sham, a con. There are 6.4 million people who are paying twice for health care and all they want is a fair crack of the whip, they do not want the impossible. I have spoken to a family who have got £3.9 million before Christmas, the Edwards case, the lawyer is here today who dealt with that case. It does not mean a thing to them. It is the twelve years it has taken to get their case heard. I was not chasing money but it cost me £14,000. I was determined, it is only the cost of a car, I just got another MOT for mine, no problem at all. When I wrote to Health Ministers, I showed them this report and in this report a very important document which says that Tees Health Authority hoped that this complaint will not happen again, but in reality we never know. So we want to ask the Nuffield Hospital Group to form part of an agreement of steps to be taken for future private health, patients complaints, because this has taken four years, it is public money that has gone into this report and everything else. The Nuffield Hospital in December 1997 turned that request down saying that there is no statutory requirement for them to do that, which is right, but all our members think, "I thought the patients were the most important thing." Them turning that down has highlighted to our own members that it is business first and a caring profession second. They are a registered charity. Well, a charity to me is like the hospices I work for who have to stand on a street corner with tin cans to keep the doors open, not hospitals charging £250 a night. They then said that these hospitals are inspected twice a year. So I got copies of the inspection reports and in 1996 that same hospital just had two investigations, 36 bedrooms, the total man hours inspecting that acute hospital was two hours 45 minutes. It is a nonsense. This was produced in June 1997, seven days before this one, the same hospital was given a glowing report, so the two inspectors must have been passing each other in the corridor. The glowing report was about the quality of the food and the lighting.

235. I will have to bring some of my colleagues in but we are genuinely most grateful because it is important we hear about your experiences.

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Chairman Cont]

(Mr Maloney) I am sorry, I have gone on. Thank you.

Mr Walter

236. This question is probably directed at the Action for Victims of Medical Accidents but I would be happy to listen to an answer from the other organisation as well. I want to be able to quantify this and get it into proportion if we could. We are talking principally about surgical problems rather than medical, are we, in terms of the cases you are dealing with? Perhaps you could give some idea of the proportions there. Secondly, I wonder if you could give us some idea of the proportion of the cases you deal with in the private sector as opposed to the National Health Service, whether those are in strict proportion to the number of treatments which are carried out in the private sector as opposed to the National Health Service. How do those balance out?

(Mr Simanowitz) We are in some difficulty so far as that is concerned. We have not put it in our written evidence for good reason, we do not have the statistics, the hard evidence you would like to have, and that is really because of what I touched on in my opening, that in a way the problem with the private sector has crept up on us and we have become aware of it. We have not identified the differences. We were dealing mostly with the NHS and then suddenly we became aware that the numbers were increasing. As Dr Hines will confirm, there is an increase in our case work and indeed before coming here today she did a quick trawl of the last two months and in the last two months we opened 161 files, of which 20 came from the independent sector, which is about 12½ per cent, which is quite a large number. You heard the reasons why in all sorts of other areas people do not actually complain, which brings me on to whether it is surgical only. We do deal with a larger number of surgical but we deal with the other problems as well, problems with clinics, problems with GPs. I do not know whether Dr Hines wants to elaborate on that?

(Dr Hines) We deal with a broad span. We will also deal with complaints about alternative therapists as well, about osteopaths and people like that, which the Consumers' Association were talking about, although they were not included in any of the files I sampled but I did include dentists.

237. You do not have any specific statistical evidence?

(Mrs Buckley) I was going to back that up because that is almost the biggest problem, there are no statistics published. We need statistics like post-operative mortality rates or statistics of patients who have had surgery, or not had surgery, who might then be transferred to NHS ITUs. I am sure they all keep their statistics but there is no statutory legislation which says, "What are your statistics for 1999" or whatever. We simply do not know. It takes somebody to say why, what, like we have done to try and get this into the open.

(Mr Lambie) There is one point—well more than one—which differentiates the private sector from the public and that is the effect on the families. In the NHS when there is a medical accident of any kind, surgical or medical, there is a procedure and patients feel they are listened to. It is not perfect, I well know

that, but it is there and they can get explanations, they can appeal if they do not like the explanations, to an independent tribunal and eventually to the Ombudsman. We were left floundering and it has immense effects on the families—divorces, families breaking up because the brothers felt it should be dropped and the sisters felt it should be continued, actual break-ups of families and, as somebody said, bankruptcy; several of those. Two things I would plead for this Committee to do today. One is to forever kill the mantra which comes out of the private sector that they are inspected twice a year and that they are accredited by the King's Fund or the IOS or whatever. On inspections, I have a letter from the Department of Health stating quite clearly that the inspectors are not allowed to look at the clinical picture in that hospital in any way. They cannot ask for clinical statistics which would be relevant to this.

Chairman

238. Could we possibly have a copy of that letter?

(Mr Lambie) Yes. I think it might have been in my file to you.

239. If it has been sent, I have missed it, but what you have just said is very important.

(Mr Lambie) Exactly. That is absolutely clear, yet time and time again the private sector will say, "We are inspected twice a year by the health authorities who license us." That is another question, the possible conflict of interest. And then accreditation. These accreditations are on the efficiency of the running of the hospital. It is an organisational survey which again does not go into the clinical care of the patients. It is really unbelievable.

Audrey Wise

240. Do you agree with our previous witnesses that this actually amounts to a false reassurance?

(Mr Lambie) Absolutely.

(Mr Maloney) Absolutely.

(Mrs Buckley) We are all quite expert now because we have read our submissions but the lay person reads the brochure, they look at that. To go back to a point just now, I think it is very important within legislation if possibly hospitals could be graded according to the cases that they can look after. There are so many cases that are taken on—my mother's was one, even though it was a routine hysterectomy it went horribly wrong—and they cannot deal with them. They simply cannot deal with them. They will take on all of them because it is a financial situation.

(Mr Maloney) I would like to say just as a member of the public, (because I do not pretend to be an expert on anything) that life goes on, but life cannot go on when there is no framework to have a complaint heard within a period of time. We are not criminals, we are just members of the public who believe what they read and pay extra for our health care. For that we understand that things can go wrong but it is criminal if we have to pursue complaints for years and years and years and spend extra money on top of that to get to the truth. At what cost the truth? The truth should not cost anything at all, but it does within the private sector, and that is the most frustrating part.

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Audrey Wise Cont]

241. Do you feel that the conflict of interest between the clinical provision and the commercial function is of enormous importance? Mr Maloney I know does because he said it is business first and clinical care after. Is that the general view?

(*Mr Simanowitz*) I think there is an obvious conflict of interest because the hospital wants the patients, the hospital does not want to upset the doctors, conversely the doctors want the practising privileges so they do not want to upset the hospital. They have to keep these two issues separate, they have to keep complaints separate, and they do not interfere in any way with the monitoring because of this inherent conflict of interest.

242. It seems from what you have said that the private hospitals choose to push the things that they regard as saleable assets, like private rooms and so on, thick carpets, and that sort of reinforces that they are actually selling something?

(*Mr Lambie*) Very much so.

(*Mr Maloney*) All the time.

243. To go back to Mr Maloney, I was interested in everything you said but there was one thing you said near the end, that you were able to get the health authority to take an interest in this matter of the drugs because you provided the evidence.

(*Mr Maloney*) Yes.

Audrey Wise: Most people would not have had the wit or perhaps sometimes the opportunity to get hold of the drugs chart.

Chairman: They are not all from Liverpool, are they!

Audrey Wise

244. Do you think it is unreasonable to say that that is what the health authority's inquiry should have been doing? It is not much good taking something up if somebody else provides the evidence, should they not look for the evidence?

(*Mr Maloney*) Absolutely right, Chairman, and that is a very good point. I was led to believe with an acute hospital, with the expertise that they have, that the health authority monitoring them would look at that. It is all written down, the night of 23rd November 1993 there were discrepancies—the dosages prescribed did not agree with what was given, it was quite appalling and dangerous—and that has been going on in that hospital for three years. I pointed this out to Tees Health Authority, "You have inspected that hospital twice a year, so there have been possibly seven inspections, maybe eight since 1993, did any of those inspections pick up what I have identified here by me taking this drugs prescribing chart?" We all sat down and looked at it and not one of those areas was picked up in those four years. Then I said, "You interviewed staff in May and June of 1997 and they were speaking in the present tense that the drugs administration and recording system had not changed since 1993, so the reasons why you recommended the drugs administration to be reviewed—it is unreliable and therefore open to error—has been going on for three years." That is the type of thing I thought they would be looking at when they investigated and inspected private hospitals.

(*Mr Simanowitz*) The fundamental flaw goes back to the registration. The reason why the health authorities are reluctant and are not equipped to do this kind of investigation is because the registration relates only to the nursing home type provision. They are not concerned with the quality of care. I think it would be quite wrong to try and graft on to that kind of regulation a duty on the health authority to go into it in a much deeper way.

Chairman

245. This came up in our session last week where we actually had a practising registered homes inspector who did give us information—somebody not far from where you are in North Yorkshire—about the ways and means by which they can look into clinical performance in these hospitals. Mr Lambie, you were saying in your letter the Department of Health were saying that could not happen, but it appears to be that we have information that it is happening in certain parts of the country. So it seems very confusing.

(*Mr Lambie*) Great, and it should be. The fact is, of course, as Mr Simanowitz says, these hospitals are registered as nursing homes so when I went to my health authority and twice asked for an investigation of the procedures in the Nuffield Hospital in Woking where my wife was, they came back and said that his inspection showed that the practices in the hospital conformed with the 1984 Act.

246. "The practices"?

(*Mr Lambie*) The practices in that hospital. There were several other things which I wanted to see were raised. People think they are going into a private hospital under the sole charge of a consultant, and they are, but as somebody else said the RMO is not allowed to examine them, or do anything except under strict instructions. These consultants are going in there on their own, they have no back-up registrars, they have no consultants in different disciplines who could say, "I think that patient may have so-and-so", and they have no trained specialist nurses. The nurses are generalists, they have to be, they have to nurse every type of patient, other than what is cut off like maternity which the hospitals are not allowed to admit. So the man is very often out of his depth with all due respect to him being a consultant.

Audrey Wise

247. Finally, it seems to me that there is a rather incestuous relationship here between the consultant in his role as an NHS consultant and then his work in these hospitals. Do you think it would be helpful if the NHS said to its consultants, "You are NHS and that is what you will be and you cannot go into a private hospital"? Do you think that would perhaps make it easier to get NHS treatment when you need it and perhaps make it less likely that there could be a growth of the sort of private hospital treatment which has been mentioned?

(*Mr Simanowitz*) I think the facts speak for themselves. One has to be careful about the implications of that. The medical profession does not take kindly to that sort of dictat and the way they

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Audrey Wise Cont]

would respond if they were told they could not do both might well be that some of them will opt for private work only at this stage.

Audrey Wise: They would have difficulty, would they not, because where would all the back-up be? They could not suddenly walk down the road to be in a Nuffield Hospital, could they?

Chairman

248. I think many would also share the concerns you are expressing. Many of them are unhappy, even those who work part-time in the private sector or part-time in the Health Service, very unhappy about the circumstances you have described.

(Mr Simanowitz) That is absolutely right because the facts do speak for themselves, and many of the cases we see arise because the consultant is not available at the right time, does not spend enough time with the patient, which is after all what his or her duty is.

(Mrs Buckley) A lot of the consultants who work on the NHS and double-up do their long NHS day and then they go to the private sector. My mother was operated on at 7 o'clock at night. They are very early operations or very late operations and the ratio between how many hours on the NHS and how many in the private sector would be a very interesting one to examine simply from the safety aspect. They have done a hard day on the NHS, done lots of operations, and then off they go to the private hospital for the evening's operations with no back-up.

(Ms Ryb) Emphasising that, the cardiac surgeon who came to operate on my father from the local NHS hospital, when he was finished he actually went back to the NHS hospital and spent the rest of the day and evening operating there.

(Mr Simanowitz) Mrs Wise said that they would not have the back-up and therefore they would not do it, but you would have to go one step back and say, "They cannot do it without the back-up", that is the kind of regulation we are looking for. Once you say that, then they would find it impossible to opt out of the NHS.

Dr Brand

249. Mr Chairman, I think this has been a very valuable session but I think we are here talking about inadequate medical facilities for jobs that organisations are doing. I see that in the NHS just as much as in the private sector. The only problem with the private sector is that they have this commercial side to it where there is an inducement not to have things fully staffed in certain circumstances to meet all eventualities. I think the NHS on the whole is much better at that. The thing that concerned me most in Mr Maloney's very helpful evidence was the fact he was denied the existence of any complaints procedure at all.

(Mr Maloney) Yes.

250. Certainly my local inspection registration unit would not register a nursing home unless in all their literature it gave the address of the inspection registration unit, saying, "This is where you can go in case of complaint".

(Mr Maloney) Absolutely.

251. I wonder whether, as a result of the work you have done with the Nuffield Trust, they have changed their line on that because that strikes me as being totally disgraceful?

(Mr Maloney) There are three areas which would improve healthcare in private hospitals. One is exactly what you said, Dr Brand, that in all the literature they actually tell the patients their rights, you have a right to go to the registration authority, which they do not. Number two would be doctors have to be fully insured against litigation. Hospitals are well covered, the patient is not. If that patient could take out an extra policy to include litigation or accidents, it would change overnight. We have heard about the Medical Defence Union, what about the Patients Defence Union? They would automatically know. I get all my information at the local church, all the doctors are down there on a Sunday morning taking Communion and I have found out more there than at the Health Trust. At the end of the day I say if they know patients are fully insured, it would change. It would change overnight because of those two factors.

Mr Amess

252. I am desperately trying to think of a question which has not been asked whilst I have been out of the room, so if it has, I apologise. Certainly in the time I have been in Parliament, many constituents have brought complaints to me about unfortunate outcomes when they have been treated by the National Health Service. As I have been sitting here listening to you all I have desperately been trying to think of a complaint being brought to my attention from the private or independent sector and I genuinely cannot, and this is over a period of 16 years. Just to help me and I hope it has not been asked already, do you all have many Members of Parliament dealing with your goodselves directly, helping their constituents, and it has just by-passed me in Essex?

(Mr Lambie) Certainly my MP, two MPs, have been very, very helpful indeed.

(Mrs Buckley) Mine has.

(Mr Maloney) Mine without a doubt.

Chairman

253. This is getting embarrassing! Okay, we have got the picture!

(Mr Maloney) Without a doubt. Absolutely fantastic, I cannot say anything else, brilliant.

Mr Amess

254. I am grateful for that but really my point was, do you have a lot of MPs giving you lots of complaints about treatment? I am sure you are finding individual Members of Parliament are being helpful but it is the volume I would like and perhaps you could give us the statistics. Do you have MPs saying, "Here are a dozen cases, it has all gone wrong here"?

(Mr Simanowitz) We have MPs giving us cases but the majority of them are NHS cases and it is not a large quantity anyway.

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Mr Amess Cont]

(Mrs Buckley) I would also say on that point that many private patients do not understand what has happened, they do not understand the system which is available to them. Many patients do not understand that you can go to your Member of Parliament. You have to be aware of the situation, a lot of them are fobbed off before they even get that far.

(Mr Lambie) And when they are told they have two options, you either sue the doctor or you go to the GMC, both of which are equally formidable and both can be very expensive, they drop the idea. So many disappear into the mist, we could not estimate.

255. I am not contradicting either Mrs Buckley or Mr Lambie but I have represented two constituencies of different types and I have not found any of my constituents backward in coming forward, whether it be about rats or anything, they do not seem loathe to contact me about issues. That is why I was slightly surprised I have not had more complaints.

(Ms Ryb) Certainly in our case those were the only two options we were given, sue or refer to the GMC. Certainly at the time, and I was quite young, it was never suggested to me I ought to contact my MP. It was not something I thought about.

256. I am not inviting complaints by the way!

(Mr Maloney) We have all heard of the Health Ombudsman, I contacted him and even he could not tell me about my rights. I will not tell you his name, one of the assistants there. He did come back and say, "By golly, you are right, we can look at National Health investigations into private hospitals. I thought we could not investigate any." That is the problem. The information is not out there. I cannot remember anybody I have spoken to over five years, even from the private health sector, when I put my case to them, and I have wanted them to respond positively, who has contradicted me, but of course they cannot. I have always said, if it is as good as they say it is in the brochures, why are they objecting to a statutory complaints procedure. The other alarming thing is you get two beds in a private hospital, I have told this to the Tees Health Authority, one patient put there by the National Health Service because they have bought that bed, the patient being treated in the other is saying, "I am paying twice, if anything goes wrong with me I have to find another £10,000 to search for the truth", it is just not fair and is an absolute nonsense.²

Audrey Wise

257. There was an earlier question which has a sort of bearing on Mr Amess' question from our colleague, Robert Walter, who asked about proportionality. Of course the private sector in the surgical sense anyway is a relatively new growth and very, very many more procedures are carried out in the NHS than in the private sector, even though that is growing, but did I pick it up correctly—it was the AVMA witnesses—I think you said that proportionately you felt there was a disquieting number of cases involving the private sector?

(Mr Simanowitz) That is absolutely right, that is what we said. The numbers are disproportionate.

258. Can I just ask you, following on where complaints should be addressed, do you feel there needs to be some mechanism for more to be done at a local level rather than even getting an improved one at national level? Do you think it needs doing locally as well? How do you see the levels of structure?

(Mr Simanowitz) The first thing that is necessary is for the independent sector to have a proper complaints procedure. If it mirrors the NHS procedure, then the local level will be very important because some of the complaints, if they are dealt with openly and properly, are best dealt with at that level. Then, as you go up, there should be an independent review, as there is in the NHS. Now there are problems with the the NHS review and that is being investigated at the moment, there is going to be a conference later this month in which the investigation and report will be published. We see serious problems with that but it is very much better than anything which exists in the private sector. The biggest problem is that it is not seen to be independent and it is very important that if you have an independent review it should be independent, it should be outside whatever body is concerned. Then the most important thing is to have something right at the top—I think they referred to it in the earlier session as over-arching—and that is the Ombudsman. The Ombudsman's remit should absolutely, definitely, be extended so that he can look into private sector complaints. I do not agree with the idea there should be a separate ombudsman for the private sector, because then you will not see the patterns, you will not be able to compare like with like. Ideally what you need is a separate department within the Ombudsman's office which deals with the private sector but the person who is finally accountable and able to give a report which combines both sectors must be the Ombudsman himself.

259. Do you think that the professional bodies themselves as far as clinical staff are concerned ought to be required to take more responsibility for ensuring satisfactory standards? This is more to AVMA I think. I know APROP's views, I think.

(Mr Simanowitz) Provided it does not dilute the requirement of the institutions themselves. It is important, this is an area which has been neglected by the professional organisations. They move very slowly and you have heard they have now produced performance procedures, but that is after a very, very long battle, something like nine years.

² Note of Witness: If one of those beds is bought by a Health Authority and a National Health patient is treated in that bed, although a private hospital, that patient is protected by the NHS statutory complaints procedures and also has access to the community health council and health ombudsman. If the second bed is used by a private patient paying for his treatment himself or through medial insurance, he is in effect paying twice for healthcare, taking into account National Insurance contributions. If things go wrong with his care he does not have access to the statutory complaints procedure, the community health council or health ombudsman. It is that this is not fair or proper in my view.

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

[Audrey Wise Cont]

260. So these are not alternatives? You want both?

(Mr Simanowitz) Absolutely.

(Mr Lambie) This document contains all that.

Chairman

261. Can you just refer to the title of the document, so it is on the record?

(Mr Lambie) *A First Class Service*. This contains all that we would want but it is a ten year project and we need legislation now. Especially when the White Paper becomes an Act, controlling social services and private clinics and so on, it is desperately necessary for legislation to be in place now for the private acute hospitals.

Audrey Wise

262. I just wondered whether you had any views as far as the advertising side is concerned, about the role or lack of role of the Advertising Standards Authority?

(Dr Hines) I just wanted to say that you were earlier referring to the vulnerability of people who were going for cosmetic surgery and they may be particularly susceptible to pressure, but I think the stories here show that all these people are vulnerable, they are frightened, in pain or helpless, but they want to be persuaded that they are getting something better, that they are hoping they are going to be able to take some control over their illness and their bodies by spending money, by going for something better. So they are in a very vulnerable position no matter what area of private health care they are going for.

Mr Gunnell

263. Having had the very moving evidence that we have had this may seem an irrelevant question, but I will try and show how I think it is relevant. Obviously you were not concerned about the money you might have got as a result of your experiences, but you would accept that the private companies were actually very concerned about the money which they got out of it and not losing access to that money. There is one issue which has come up once or twice which I think is relevant to this, when a person goes from the private sector into the NHS, the NHS pick up the bill for that person even though that person was insured. I think the NHS, when they encounter costs which were actually insured for in the private sector, ought to make a practice of going to the private sector and making sure the private sector insurers pay the costs of that bill. Not simply because they would recover the costs and that is good for the NHS, but because only by having to pay for the mistakes they make will the private sector learn that they should be more careful not to make mistakes.

(Mr Maloney) Absolutely.

(Mr Lambie) It used to be the case that the insurance companies did pick up the bill for ICU care if an accident happened in a private hospital and the patient was transferred. It would not happen in a long-term care situation.

Chairman

264. This used to be the case?

(Mr Lambie) It used to be the case.

265. When did it change, because this is news to me?

(Mr Lambie) I watched a television programme in which the Medical Director of BUPA, defending himself against an intensive care specialist, said that these patients pay their national insurance and they are entitled to ICU care. Previously BUPA had paid—and PPP may still do, I am not sure of the situation, that would have to be checked. But BUPA certainly, according to Dr Vallance-Owen, were not going to pay any longer. BUPA has both the insurance side, of course, and a chain of hospitals. In that particular broadcast I was incensed because he replied to the criticism by saying, "We have no accident and emergency services", which is absolutely right, but the implication was that this patient had been brought in off the street, had been run over by a car say, instead of having suffered a medical accident.

Mr Gunnell

266. The new NHS Bill will set up certain arrangements for clinical governance within the NHS, for instance the National Institute for Clinical Excellence, arrangements for future care standards and a Commissioner for Health Improvement. None of those things apply to the private sector, do you feel it would be helpful if they were to apply and therefore treatment which was ruled out by the National Institute ought not to be offered in the private sector?

(Mr Lambie) Absolutely. I wholly support that.

(Mr Simanowitz) I would certainly support that and I think it is something which should happen. In particular, if you look at the requirement now under clinical governance, the chief executive of a trust will be responsible for quality, and we need the same situation in the independent sector.

267. We need the independent sector to be equally accountable?

(Mr Lambie) Absolutely.

(Mrs Buckley) Absolutely.

(Mr Maloney) Absolutely.

268. I must say that if we had only had today and the evidence we have heard today, we would all of us say you should never touch the private sector in any circumstances. We went to one place earlier this week which did seem to be a place which was doing a good job, even though it was in the private sector, but interestingly they said to us that they wished to be more accountable and they wished to have the National Institute of Clinical Excellence apply standards to them.

(Mr Simanowitz) What I am concerned about is the fact that the independent sector, the IHA, is now suggesting that that should happen. On face the face of it, that sounds a very good thing, but we know that the DoH is not too happy about that and it has all sorts of financial implications. It seems to me that the IHA can appear to be willing to do all these things when they know very well that this is something which will not happen and I think it is very important to keep your eye on the ball.

4 March 1999]

MR JOHN LAMBIE, MRS CAROLINE BUCKLEY,
MS SAMANTHA RYB, MR GRAHAM MALONEY,
MR ARNOLD SIMANOWITZ,
MS LIZ THOMAS AND DR JULIA HINES

[Continued]

Julia Drown

269. Just on this last point about whether all the regulatory bodies for the NHS should also cover the private sector, can you comment on the fact that some people go to the private sector because it is something different and it is different from the NHS? I can see that it might take a very long time for the National Institute for Clinical Excellence to approve of things like Chinese medicine, herbal medicine, acupuncture, all those sorts of things. Is there not a problem there that some people want to have these things available to them in the private sector; things which would not be validated in the NHS?

(*Mr Lambie*) We are solely concerned with private acute hospitals, so these other auxiliary medicines are not our concern.

(*Mr Simanowitz*) I think there is a difficult problem there. There are some areas where there will be a difference and I think an allowance should be made for those differences. There is no reason why the body should not control or have influence there and allowance can be made. On that specific point, if it is taking a long time and until it happens we do not know whether it is safe or not, I cannot see any justification for the independent sector using it, even if the public are anxious to do so.

Audrey Wise

270. Do you make a distinction between the private sector, in the sense of profit-making, and the independent sector, in the sense of not-for-profit organisations?

(*Mr Simanowitz*) There has not been an obvious difference to us in perception.

Chairman

271. Would that be your opinion as well?

(*Mr Lambie*) That is our opinion also.

272. Any other quick question questions from colleagues before we conclude? Do any of the witnesses wish to add anything?

(*Mr Maloney*) Just on the insurance thing which I found again scandalous, when I said to my insurance company, "Look, you have just paid out £12,000 for

a young lady's care and it has been proven it was poor, do you want to get some of that money back?" Because if they paid it—which they did—they were condoning bad practice. "Surely your responsibility is to look at the care your patients are getting or not getting?" Where does the buck stop? It cannot be left to the patients all the time. I have mentioned before that I am sure if litigation cover was included in your policy things would be better. I have already approached Abbey National because they have started to sell these things. I am a bit of a shareholder so I wrote to the business development manager, and I will give you a copy of the letter, and I basically said, "I am sure you want to sell a product equal to your mortgages and anything else you sell to the public, would you consider including legal cover?" They are looking into that. They did say, "You can take out house contents insurance for £30,000" but I said, "If you are driving a car on the house insurance and have an accident, it would not work, and for the same reason it would not work if you have a medical accident and have to rely on house contents insurance". But they are looking at that. Commercially it would be massive, of course, and it would be hardly any expense to the Government. These people are selling themselves as the best, if they fall down, let them pay for it.

(*Mr Simanowitz*) Just to pick up a point which was made earlier and to reinforce it, the independent sector needs more regulation, not less, and that is because there is self-regulation in the NHS. They work within teams, there are other doctors there, there are qualified nurses, there is this whole panoply of regulation which is informal which does not exist in the independent sector.

(*Mrs Buckley*) I think it is very easy to lose sight, with all the paperwork and everything else that happens, of the reality of why we are here, our loved ones would be here today if they had been nursed on the NHS in an acute situation.

Chairman: Can I thank you all very much on behalf of the Committee for your most helpful evidence and for sharing with us some very distressing experiences. We do appreciate you coming along today.

THURSDAY 25 MARCH 1999

Members present:

Mr David Hinchliffe, in the Chair

Mr David Amess
Mr John Austin
Dr Peter Brand
Julia Drown

Mr Ivan Lewis
Dr Howard Stoate
Mr Robert Walter
Audrey Wise

Memorandum by Independent Healthcare Association

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 58)

Contents

Outline Contents

[illegible]

Detailed Contents

[illegible]

25 March 1999]

[Continued

Overview of the sector and providers	...	...	...	...	...	...	...	...	...	...
Employed Consultant Staff	...	...	...	...	...	...	...	...	...	...
Funding	...	...	...	...	...	...	...	...	...	...
Registration and Inspection	...	...	...	...	...	...	...	...	...	...
Mental Health Act 1983 and Commission	...	...	...	...	...	...	...	...	...	...
Regulation by purchasers	...	...	...	...	...	...	...	...	...	...
The Government's Mental Health Strategy	...	...	...	...	...	...	...	...	...	...
Self-Regulation	...	...	...	...	...	...	...	...	...	...
Patient Complaints...	...	...	...	...	...	...	...	...	...	...
Summary: Mental Health	...	...	...	...	...	...	...	...	...	...
Section 4: Unregulated providers	...	...	...	...	...	...	...	...	...	...
NHS Private Patient facilities	...	...	...	...	...	...	...	...	...	...
Cosmetic Surgery	...	...	...	...	...	...	...	...	...	...
Surgery in consulting rooms and GP premises	...	...	...	...	...	...	...	...	...	...
Isolated professional practice	...	...	...	...	...	...	...	...	...	...
Substance misuse clinics registered only as care homes	...	...	...	...	...	...	...	...	...	...
Private ambulances...	...	...	...	...	...	...	...	...	...	...
Section 5: Options for regulatory reform...	...	...	...	...	...	...	...	...	...	...
Principles for new regulations	...	...	...	...	...	...	...	...	...	...
Practical regulatory options	...	...	...	...	...	...	...	...	...	...
Next Steps	...	...	...	...	...	...	...	...	...	...

SUMMARY OF MAIN CONCLUSIONS

The Health Committee inquiry

The Independent Healthcare Association (IHA) and its members welcome the Health Committee's inquiry. The Association hopes that this inquiry will stimulate legislative reforms to give UK healthcare a coherent and effective system of regulation.

The Association's members believe in the quality of care and quality of service they deliver. The right new regulatory system could help providers to ensure that patient's can be confident in independent healthcare providers.

The independent sector is a major provider of healthcare in the UK, a large employer, and a vital part of the UK's strategic healthcare cluster.

The evidence covers acute medical/surgical hospitals, mental health hospitals, and gaps in the regulation provided by the Registered Homes Act 1984.

Acute medical/surgical hospitals

There are nearly 11,000 independent acute medical/surgical beds in the UK. Of the 850,000 patients operated on per year, 70 per cent is funded by medical insurance, 20 per cent is privately self-paid and 5 per cent is NHS funded.

Typically, independent hospitals grant practising privileges to self-employed consultants. There are some exceptions where a hospital directly employs consultants.

The Independent Healthcare Association has a raft of initiatives to build a coherent system of clinical governance for the independent sector. This includes quality assurance, clinical governance and audit frameworks, and complaints handling and independent review.

The vast majority of Independent Healthcare Association member hospitals already have independently certified quality assurance schemes. The remainder will have by the end of 1999. More independent hospitals have achieved King's Fund Health Quality Service Full Accreditation than NHS hospitals.

The revised and strengthened Independent Healthcare Association Code of Practice on Patient Complaints is currently out for consultation with consumer and patient groups. IHA is implementing a mechanism for the independent review of unresolved complaints.

25 March 1999]

[Continued

There are many influences on independent hospitals that encourage them to deliver a high standard of care, of which regulation is but one. At present the Registered Homes Act 1984 is not making a significant positive contribution to quality of care. There are serious flaws with the structure and operation of the regulatory system of the Act.

Mental health hospitals

There are nearly 2,500 independent acute psychiatric and substance misuse beds in the UK. A substantial proportion of their services are supplied under contract to the public sector as “ECRs” or longer-term arrangements. These units often directly employ consultant psychiatrists.

Psychiatric and substance misuse providers are registered under the Registered Homes Act 1984, and also may come under the Mental Health Act 1983. The Mental Health Act system is integrated across the NHS and the independent sector and appears to work well.

Medical insurers and NHS purchasers also exercise oversight. Mental health members of the Independent Healthcare Association are committed to independent quality assurance systems and are signed up to a Code of Practice.

Services outside direct regulation

The current healthcare regulatory system has gaps, which include NHS private patient facilities, some cosmetic surgery, other minor surgery in unregulated premises, isolated professional practice (including complementary medicine), some substance misuse clinics registered as residential homes, and private ambulances.

The regulatory system should cover all independent healthcare providers, unless there are clear and defined reasons to the contrary.

New regulations—principles and options

Some of the principles for a new regulatory system should include:

- Fitness for purpose—protecting patients and enhancing their rights
- Full coverage of the healthcare sector
- Outcome focused
- Culturally oriented towards healthcare
- Light of touch
- Regulate organisations and people
- Integration for quality standards and good practice
- Differentiation of management and finance

The Independent Healthcare Association supports the extension of the Health Service Commissioner’s remit to cover not just NHS commissioned independent care but all independent healthcare. There are some technical difficulties with such a proposal but they could be overcome. This would provide an extra layer of review over the independent sector’s own complaints handling and independent review systems.

The Independent Healthcare Association’s preferred option would be NICE and CHI being implemented for both the NHS and the independent sector. Alternatively, there should be a new national regulatory or self-regulatory body for independent healthcare.

Independent healthcare providers are demonstrably committed to delivering the highest quality of care, and would welcome moves to create a regulatory system that did more to support that goal. IHA very much hopes this Inquiry will help that to come about.

SECTION 1: OVERVIEW OF THE EVIDENCE

1. The Independent Healthcare Association welcomes the Health Select Committee’s inquiry into the regulation of independent healthcare. The Association hopes that this inquiry will help form government policy, and deliver regulatory reforms that IHA has long campaigned for and our members long desired.

2. The mainstream independent healthcare providers are committed to delivering the highest standards of care, and to demonstrating that they deliver the highest standards of care. A good regulatory system should support this commitment and help to spread best practice across the entire UK healthcare sector. A good regulatory system would also ensure that should any provider in whatever part of the UK healthcare system not be delivering high standards of care they improve or cease to operate.

25 March 1999]

[Continued]

3. IHA members are proud of the service they provide and the quality of care they deliver. The right regulatory system would help all providers to continuously improve and ensure that patients are confident that they will receive the care they need and deserve.

4. In this evidence, the IHA sets out:

- Steps IHA members have taken to ensure quality of care and good complaints handling;
- The Association's experiences of the current regulatory system;
- The principles and options that our experience suggests should apply to a new system;
- Areas of provision overlooked by the current regulatory regime.

IHA's evidence was developed with the assistance of a steering group, to ensure that the evidence presented is representative of the views and experiences of IHA's members. The steering group membership is listed in Annex 1.¹

5. The evidence looks at the issues specific to different types of providers as well as considering the general issues common to all.

6. Some factual background information on the Association, the independent healthcare sector, and the current regulatory system is included in annexes to this memorandum, for the Health Committee's further information.

What is the Independent Healthcare Association?

7. The Independent Healthcare Association (IHA or the Association) is the representative association of independent health and social care providers. Its members include acute hospitals, psychiatric hospitals, nursing homes, and residential care homes.

8. The IHA was formed in 1987 by the merger of two earlier associations. It is a registered charity (296103), incorporated under the Companies Acts (2082270), being a company limited by guarantee not having a share capital.

9. The principal activities of the Association are to promote and protect standards of healthcare in the independent sector. In addition, the Association acts as a forum for discussions among independent health and social care organisations.

10. The Association maintains consultation with Government and other bodies on the provision of medical, nursing and social care within the United Kingdom; analyses and disseminates information to members; promotes knowledge of the independent sector to the general public and encourages the right of individuals to choose independent care.

11. Independent hospitals, mental health hospitals and care homes are already a major part of the nation's health and care services. Rather than work in isolation from the public sector, the IHA and its members believe the future lies in partnership. Agreements between the public and independent sectors already offer purchasers access to a wide range of high quality, best value services not available elsewhere.

Who are the IHA's members?

12. IHA's membership ranges from services run by trade unions, friendly societies and charities, to services provided by—large and small—commercial organisations. IHA represents health and care providers who, in total, operate over 80,000 beds and have an annual turnover of almost £3 billion.

13. There are three main groups of IHA members:

- Acute Hospitals: representing over 9,000 acute beds in 175 hospitals, the IHA Acute group includes all the main independent hospital operators and in total about 90 per cent of the UK's independent acute hospital provision. IHA members provide a full range of elective hospital services, from the simple to the complex. Independent acute hospitals treat millions of people and perform nearly 1 million surgical procedures each year, mostly privately funded.
- Mental Health: representing over 1,600 beds in acute psychiatric hospitals and substance misuse units. These 24 units comprise two thirds of the total independent acute mental health provision. Independent mental health providers are major suppliers to the NHS. For some types of service, the independent sector supplies the majority of the NHS's requirements.
- Community Care: representing over 70,000 nursing home and residential care home beds, IHA is the largest association of care homes in the UK. IHA represents the major corporate and not-for-profit groups, along side smaller homes. The majority of care in independent homes is publicly funded via local authority social services departments, the NHS and social security benefits.

¹Annexes not printed.

25 March 1999]

[Continued

14. The IHA membership also includes providers of home care services, pathology laboratories, screening units and a host of other associated health and care companies. The Association's main member organisations are listed in Annex 2.

15. Overall the entire independent health and social care sector, including acute and mental health hospitals, home care and nursing and residential care homes employs more than 750,000 people. Beyond that, independent provision is as much a vital part of the UK's successful healthcare strategic cluster as are the NHS or pharmaceuticals companies. The UK is a world centre of excellence in healthcare and the independent sector is an integral part of that.

The scope of the Health Committee inquiry

16. In considering its evidence, IHA concluded that the potential range of services covered was so great that the Association would have to make some assumptions about the areas of interest to the Committee. The areas on which this memorandum focuses are:

- Mainstream independent acute medical/surgical hospitals.
- Mainstream independent mental health services.
- Acute healthcare services that can fall outside current regulations, such as cosmetic surgery, NHS private patients units, private ambulances, and professional consultations.

17. IHA uses the term "*independent* healthcare" to encompass all non-public sector healthcare provision. None of the other terms have sufficient or agreed scope. The term "*private*" is inadequate to the task: the NHS supplies some private healthcare, and the independent sector provides NHS services under contract. Further, some independent providers do not consider themselves to be "private sector". IHA uses "private healthcare" to refer to the commercial supply of healthcare to paying clients.

18. IHA understands that there is a small amount of non-NHS public sector healthcare, such as Ministry of Defence hyperbaric services, but this is outside our experience and this evidence.

19. IHA estimates that the total turnover of a broadly defined UK independent health and social care sector is nearly £17 billion (see Exhibit 1, compiled from various sources). With all the complexities of the health and social care sector this figure can only be a rough estimate, but it represents about 25 per cent of all UK health and social care spending.

EXHIBIT 1: TOTAL UK INDEPENDENT HEALTH AND SOCIAL CARE SUPPLIED, 1997-98

	£m	£m		£m	£m
Acute medical/surgical	1,250		Dentistry	230	
Acute mental health	94		Ophthalmics	790	
Other	81		Private GP services	315	
Independent hospital revenue		1,425	Complementary medicine	570	
Specialist fees	631	631	Pharmaceuticals etc.	3,120	
Total acute healthcare		2,056	Total other direct healthcare		5,025
Nursing and care homes	6,917	6,917	Independent medical research	2,500	2,500
			Total independent health and social care		16,498

20. Nursing homes are covered by clear Government initiatives, outlined in the White Paper, *Modernising Social Services*, which moves in the direction IHA has long sought. Other initiatives include *National Required Standards*, *Best Value*, the *Long-term care charter*, and the Royal Commission on long-term Care. IHA understands that nursing homes are not the main focus of the Committee's interest in this inquiry. Some background on nursing homes and new social services regulatory proposals is presented in Annex 3.

21. Should the Committee choose to look into nursing homes in detail the IHA has a similar wealth of experience in that area. The same is true of most other aspects of independent care provision, or issues related to it, although the Association would need the opportunity to consult with members and collate information.

22. Exhibit 2 shows some of the range of services that comprise "healthcare outside the NHS". The most basic division for the purposes of this memorandum is between those services where the standard of care and service is directly regulated and those where it is not. There are of course many indirect regulatory mechanisms, such as professional registration.

25 March 1999]

[Continued]

EXHIBIT 2: DIRECTLY REGULATED AND UNREGULATED HEALTH SERVICES

<i>Directly Regulated</i>	<i>Not Directly Regulated</i>
Acute Medical/Surgical	
Independent hospitals, covering full range of services including:	Minor surgery in professional premises (eg minor cosmetic services, GP practices, and dental surgeries)
— cardiac surgery	NHS paybeds and private patient wings within NHS hospitals
— neurosurgery	Lasers of class 1, 2 and 3A (when outside independent hospitals)
— oncology and radiotherapy	Free-standing clinical support services, eg pathology, MRI, CAT scans etc
— reconstructive plastic surgery	Health Screening outside of hospitals
— orthopaedics and general surgery	Independent consulting practice by healthcare professionals
— ITU and HDU	
Lasers of class 3B or 4	
Termination of pregnancy	
IVF and other HFEA regulated	
Mental Health	
Independent mental health homes and hospitals, including:	Therapists and counsellors practising outside of mental health facilities
— acute mental illness	Substance misuse clinics registered only as residential homes
— medium secure	
— learning disabilities	
— brain injury rehabilitation	
— substance misuse rehabilitation	
— eating disorders	
— elderly mentally ill	
Nursing Care	
Nursing Homes, including:	Domiciliary care
— care of the elderly	Day-care centres
— physically disabled	Sheltered housing and “housing with care”
— palliative care	
— degenerative conditions	
Dual registered homes	
Nursing Agencies	
Primary Care and/or community services	Private General Practitioners
	Walk-in primary care services
	Complementary medicine
	Retail pharmacy/chemists
	Private ambulance services

SECTION 2: ACUTE MEDICAL/SURGICAL HOSPITALS

23. This section looks at the regulation, monitoring and inspection of independent sector acute providers. Under the Registered Homes Act 1984 health authorities register and inspect “nursing homes” on behalf of the Secretary of State. At present an acute hospital is considered to be a nursing home with an operating theatre. Perhaps this was reasonable 15 years ago. It is not a good model of a modern hospital. IHA is keen to see an updated regulatory system that reflects the modern, full-service, high-technology, independent hospitals around today.

25 March 1999]

[Continued]

Overview of sector and providers

24. Independent hospitals have a diverse history and ownership. For example, the four largest hospital operators are a private company, a provident association, a charity and a quoted public company. There are also independent hospitals run by religious orders, set up by trades unions, or incorporated by Royal Charter. Exhibit 3 lists the major providers.

EXHIBIT 3: INDEPENDENT HOSPITAL PROVIDERS (BY BED NUMBERS)

<i>Provider</i>	<i>Units</i>	<i>Beds</i>	<i>% total beds</i>
General Healthcare Group (BMI Hospitals)	40	2,273	22%
BUPA Hospitals	36	1,883	18%
Nuffield Hospitals	38	1,580	16%
CHG	21	859	8%
PPP/Columbia Healthcare	4	580	6%
St Martins Healthcare	3	205	2%
Other groups and single hospitals	79	3,169	30%
Total	211	10,549	100%

25. Independent acute medical/surgical hospitals provide a wide range of care services. The vast majority of the hospital's work is elective surgery or medical care, paid for either by private medical insurance (70 per cent) or direct payment by the patient (20 per cent). The remainder is made up of work on behalf of the NHS (5 per cent) and other groups such as overseas patients (5 per cent).

26. There is at present no funding mechanism to support an independent "blue light" emergency service, although hospitals will respond to internal emergencies and deal with urgent admissions. The first GP-led independent casualty service has recently been opened at the Manor House Hospital.

27. Hospitals vary in size and specialisation. Units tend to be smaller but more specialised than NHS hospitals. Independent hospitals average about 50 inpatient beds. The size and location of independent hospitals is very much driven by the existence of local demand, and thus mostly by the local penetration of private medical insurance (PMI). The spectrum of hospitals in the NHS—from community hospitals, through DGHs to teaching hospitals is mirrored in the independent sector. There are smaller local units, medium-sized elective surgery centres, and larger full-spectrum independent hospitals. The larger units are typically found in major population centres.

28. The independent sector has made major investments in advanced facilities, including scanners, high dependency and intensive care facilities, and specialist facilities such as radiotherapy. The breadth of facilities, as in the NHS, will reflect the nature of the hospitals work.

29. A definitive survey of current activity in the sector will be published in the near future. IHA and the Association of British Insurers commissioned Professor Brian Williams to repeat the studies he conducted for the Department of Health in the 1980s and early 1990s. Exhibit 4 shows the profile of procedures the sector performed from 1986 to 1993. Since then the number of patients per year the sector operates on has risen to around 850,000 from 650,000.

Consultant staff

30. Most independent acute hospitals do not employ consultants. Instead they grant practising privileges to self-employed consultants, most of whom also work in the NHS. Consultants may well have practising privileges at more than one independent hospital. After the GP, the consultant is usually the first point of contact for the private patient, and the hospital is selected taking into account the advice of the consultant.

31. There are a number of exceptions, where a hospital employs full-time consultants, and arrangements in psychiatric hospitals are often different (see Section 3). Also, when patients come to the hospital directly—for example on a contract from the NHS—the consultant may well be employed by the hospital on a sessional basis.

32. The patient has a relationship with both the consultant and the hospital. To provide a good service to patients, the hospital and consultant will work together. Increasingly, the terms of which the consultant works in the hospital are being formalised and included in the practising privileges documentation. This will cover topics such as credentialling of surgeons, medical records, and clinical governance and audit.

25 March 1999]

[Continued]

33. Even the NHS, with several times the volume of work of the independent sector, can find it challenging to maintain geographical accessibility and high levels of specialisation. The greater the degree of specialisation, the larger the population required to give that consultant a full workload. The sharing of consultants between the NHS and the independent sector allows a greater degree of specialisation, to the benefit of patients in both sectors.

34. The recent KPMG survey of NHS consultant's working hours shows that there is no substance to any claims that the independent sector is dependent on consultants failing to meet their NHS commitments. Private practice income is an important part of many NHS consultants' total income.

Quality drivers

35. There are a large number of influences that encourage an independent hospital to deliver high quality care, starting with the basic commitment of the organisations as health care providers to helping patients. Even if one or more of these drivers of quality were to be absent, the other influences will continue to encourage a high quality of care. At present the regulatory framework is making only a limited positive contribution. Quality remains high because regulation is by no means the most important driver for quality, but regulation could make a greater contribution.

EXHIBIT 4: BREAKDOWN OF PROCEDURES PERFORMED

IHA ACUTE HOSPITAL SURVEY, 1995

Estimated numbers of operations & procedures carried out in independent hospitals, inpatients and day cases

<i>Main operation/procedure</i>	<i>Total 1992-93</i>	<i>%</i>	<i>Residents of England & Wales</i>		
			<i>1981</i>	<i>1986</i>	<i>1992-93</i>
ALL KNOWN excl abortions	572,104	84.3	206,920	381,605	557,451
Lens operations	15,875	2.3	3,935	8,491	15,356
Other eye operations	9,902	1.5	3,086	6,125	8,896
Tonsils & adenoids	13,031	1.9	9,229	12,115	13,092
Other ENT	31,880	4.7	12,811	24,789	31,784
Dental extraction	21,655	3.2	7,344	14,504	21,587
Coronary artery bypass graft	6,463	1.0	374	929	3,809
All other heart operations	7,604	1.1	234	2,902	6,379
Abdominal hernia repair	16,604	2.4	9,435	15,664	16,444
Major intra-abdominal	11,191	1.6	6,117	10,198	11,107
Haemorrhoidectomy/other anal	8,715	1.3	5,483	6,562	8,595
Appendicectomy	1,947	0.3	1,694	2,350	1,947
Prostatectomy	9,802	1.4	2,803	4,585	9,756
Vasectomy	4,396	0.6	2,546	4,912	4,393
Circumcision	3,342	0.5	2,490	3,605	3,342
Dilatation & curettage	12,420	1.8	11,973	20,915	12,350
All hysterectomy	16,216	2.4	9,211	13,843	16,146
Division, ligation, oviducts	1,925	0.3	4,035	2,819	1,827
Other gynaecological	31,492	4.6	6,629	11,071	31,069
Arthroplasty	12,787	1.9	6,328	10,080	12,637
Other orthopaedic	58,227	8.6	16,537	35,353	57,134
Ligation/stripping varicose veins	13,428	2.0	7,429	10,505	13,428
Plastic surgery	11,279	1.7	3,825	4,539	11,100
Other skin, subcutaneous	28,768	4.2	8,972	24,478	28,706
All endoscopic examinations	59,963	8.8	11,012	31,535	58,928
All other operations	84,935	12.5	36,496	64,446	82,878
No operation/procedure	78,257	11.5	16,930	34,290	74,712
<i>Abortions</i>	89,809	13.2	66,027	68,956	81,476
<i>Not known</i>	16,789	2.5	2,805	11,106	16,423
TOTAL	678,703	100.0	275,752	461,666	655,350

25 March 1999]

[Continued]

Source: Williams BT, Nicholl JP, Table IV, "Patient characteristics and clinical caseload of short stay independent hospitals in England and Wales, 1992-93" British Medical Journal 25 June 1994, vol 308, pp 1699-1701. (Published by BMJ Publishing Group).

36. The drivers for quality in an independent hospital include:

- Corporate commitment and focus on customer and patient needs
- Professional and ethical responsibilities and commitment of medical practitioners
- Desire of staff to deliver excellent standards of care and take pride in their hospital
- Requirements of hospitals on consultants, or consultants on hospitals especially through the Medical Advisory Committee and other clinical governance arrangements
- Customer and patient feedback, comments and complaints
- Oversight from powerful, informed purchasers such as major insurers or the NHS
- Selection of or advice about providers from General Practitioners
- External influences such as Royal medical colleges, the GMC or consumer groups
- Concern for maintaining a hospitals reputation and good name
- Pressure from liability insurers for good risk management and reduction
- Regulatory requirements such as the Registered Homes Act or Health & Safety

In some environments, different from the typical mainstream independent hospitals that are members of IHA, there may be fewer drivers for quality, and the limitations of the Registered Homes Act should be a cause for concern to the Committee.

Quality Assurance and Clinical Governance

37. Independent hospitals are totally committed to delivering excellent patient care. Evidence of this commitment includes the range of initiatives that hospitals have taken individually, and collectively through IHA, to develop systems that support quality care. Independent hospitals, like the NHS, are also going through a process of formalising systems and procedures that have in the past been managed more informally.

38. The vast majority of IHA member hospitals—about 90 per cent—are already independently certified to a credible industry-proved quality assurance system. The remainder must be so by the end of 1999 in order to remain members of IHA and are publicly committed to doing so.

39. The four schemes that at present meet the criteria of being credible, independently certified, whole hospital, pass-fail, quality assurance systems are:

- King's Fund Health Quality Service
- Hospital Accreditation Programme
- UKAS accredited ISO9000 Series certification
- EQMF Business Excellence Model with ValidScore certification from the BQF

40. As an example of the scale of the Association's commitment there are more independent hospitals than NHS hospitals that have achieved King's Fund HQS Full Accreditation. The investment of time, money and effort runs to many millions of pounds.

41. The IHA's commitment to independently certified quality assurance for all member hospitals by the end of 1999 is just one of a number of initiatives that are part of the ongoing programme on hospital quality and governance systems. Some of the other initiatives are listed in Exhibit 5. Taken overall these separate initiatives form a coherent whole. IHA and its members are working to ensure that the independent sector has modern systems of governance and accountability that ensure patient's quality of care and confidence in the quality of care.

EXHIBIT 5: ACUTE HOSPITAL QUALITY AND GOVERNANCE INITIATIVES

Guidance on credentialling surgeons for Minimally Invasive Surgery and novel procedures	1993—Industry agreed guidance on the process for credentialling surgeons and assuring hospitals are equipped and staff trained for new procedures and techniques. This guidance is included in Annex 4.
Externally-certified quality assurance membership requirement	1997—required IHA members to commit to externally certified quality assurance, to be achieved by end of 1999.
A Guide to Standards in Private Practice	1997—basic framework of responsibilities of various

25 March 1999]

[Continued

Code of Practice on Patient's Complaints	parties involved in private practice, agreed at Private Practice Forum, a tripartite body of hospitals, consultants and insurers, included as Annex 5. 1998—updated and strengthened 1990 Code of Practice on the IHA member's internal complaints handling process. It will be a membership requirement, and is currently out for consultation with consumer groups.
Private Practice Forum Clinical Quality Framework	1998–99—A tripartite agreement setting out a framework of clinical governance and audit for private practice, under the auspices the Private Practice Forum. Discussions are ongoing. The Committee has been written to by the Chairman of the PPF about this.
Independent Review system for patient complaints	1999—Building on the Code of Practice on Patient Complaints, IHA is committed to create an independent review process for unsatisfied patient complaints. IHA is negotiating to bring consultants within its remit as well.

Patient Complaints

42. IHA's members all already have internal complaints procedures, and work hard to deliver high standards of customer care as well as high standards of patient care. Like any organisation that depends on its good reputation, there are strong incentives for independent hospitals to ensure that patients are satisfied with their care and that complaints are handled effectively.

43. The current draft of IHA's revised Code of Practice on Patient Complaints has been sent to a range of consumer and patient interests for comments. This codifies existing good practice in independent sector. It is the intention that a hospital's adherence to this Code becomes a requirement of continuing membership of IHA.

44. Regrettably, but rarely, some complaints will not be resolved to the complainant's satisfaction. This may be because the view of the facts that the hospital has formed as a result of its investigation is at odds with the patients, or perhaps the resolution that the complainant is seeking is not in the gift of the hospital.

45. To help with these circumstances IHA is developing, and will implement, a system of independent review of complaints. This will enable dissatisfied complainants to have an impartial review of whether or not their complaint has been properly handled.

46. At present the NHS Ombudsman's remit includes healthcare purchased by the NHS from the independent sector. In line with suggestions from patient and consumer groups, independent hospitals would be entirely happy to have all healthcare, whether NHS purchased or not, covered by the Health Service Commissioner's investigations. IHA is confident that such rigorous independent scrutiny would not harm but rather benefit the independent sector's reputation and could provide an additional layer over the sectors' own complaints handling and independent review procedures.

47. There are some not insignificant legal and technical issues that would have to be solved to make such a proposal work. The current statutory basis on which the Health Service Commissioner works would need to be revised. Specifically, the scope of healthcare would need to be defined, the implications of legal redress through contract would have to be analysed, and the Health Service Commissioner would need to ensure that the coherence of the role was maintained. These problems could no doubt be overcome.

Registered Homes Act 1984

48. Independent hospitals are subject to an array of regulatory measures, non-statutory inspections, quality assurance systems and more. There are few environments as heavily regulated as an independent hospital. Annex 6 lists some of these statutes and regulations.

49. The most important of these are the Registered Homes Act 1984 and, for mental health facilities—see Section 3—the Mental Health Act 1983. The Registered Homes Act provides for nursing homes, hospitals and psychiatric hospitals to be registered by health authorities and inspected at least twice per year to ensure they are delivering an “adequate” standard of care. The sanction for failing to meet the required standard is, ultimately, forced closure of the home or hospital. What “adequate” means is not clearly defined. Regulations and guidance have brought a degree of uniformity to interpretation. A detail explanation of the Registered Homes Act provisions, extracted from an earlier IHA publication, is included in Annex 7.

25 March 1999]

[Continued

50. Hospitals maintain good working relationships with health authority registration and inspection teams. However, IHA has argued for years that there are significant problems with the existing regulatory structure, and has campaigned for principled reform. There are three main concerns:

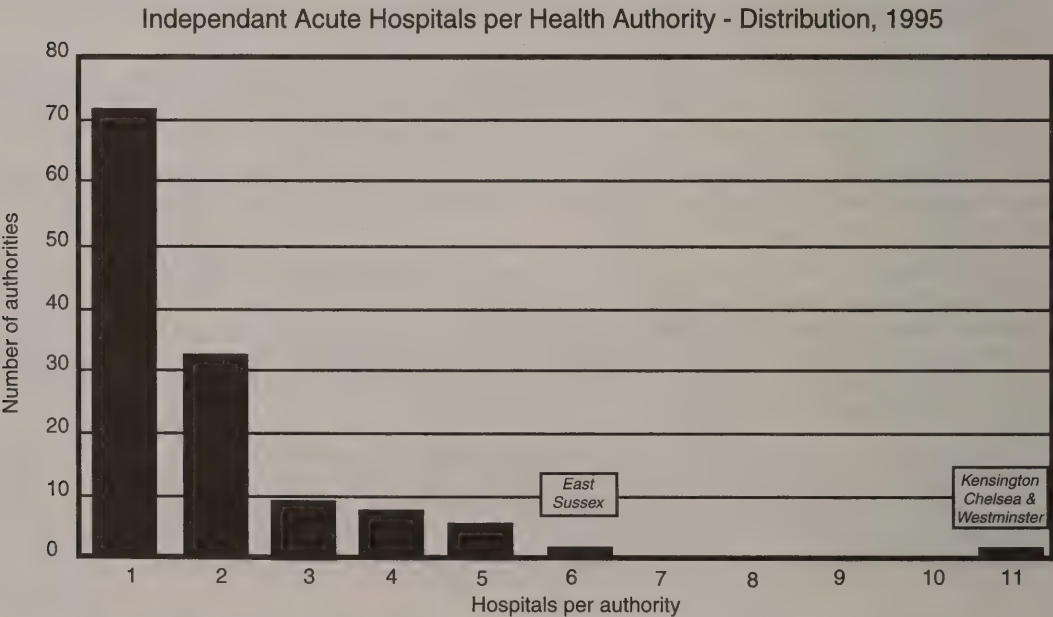
- The content of the regulations are inappropriate, focused on inputs over outcomes;
- The process of regulation can be inconsistent and arbitrary;
- Providers that are unregulated and cause concern.

The content of regulation

51. What specifics there are in the regulations under the Act focus on inputs—such as food, staff and facilities—more than outcomes. As hospitals have become more and more sophisticated, high technology environments the relevance of regulations designed for long-stay nursing homes has diminished further.

52. In principle, the system could perhaps be made to serve the needs of hospitals, but does not do so in practice. If the hospital is not an adequate hospital the inspectors can take action. If inspectors were appointed from surgeons, senior nurses and hospital managers, the inspection might focus on key clinical services and systems. Despite good working relationships with registration and inspection officers, hospital managers do not see regulation addressing the issues that are of greatest importance to the quality of care. In practice too much attention seems to be paid to the quality of hotel services and housekeeping arrangements—which are usually exemplary.

EXHIBIT 6: HEALTH AUTHORITIES BY NUMBER OF INDEPENDENT HOSPITALS, 1995



53. This is an entirely understandable consequence of the existing regulatory arrangements. Outside of central London and a few large cities, a health authority will have just one or two independent hospitals to register (see Exhibit 6). This is not an efficient scale of operations on which to organise hospital regulation. Even the multi-authority shared inspection units used by some authorities will be hard pressed to assemble a reasonable number of hospitals. In contrast health authorities would be registering close to one hundred nursing homes each, and the new regional Commissions for Care Standards proposed in *Modernising Social Services* will register and inspect upwards of a thousand units. It is IHA's view that economies of scale, as well as consistency and fairness, require hospital clinical quality regulation to be organised nationally, and preferably in partnership with NHS hospitals. It would also be beneficial to regulate independent hospitals separately from nursing homes. The regulatory needs and culture are very different. A system that regulates thousands of care homes and only a couple of hundred hospitals would have to work exceptionally hard to genuinely focus on the needs of hospitals.

*25 March 1999]**[Continued]*

54. One authority that is in a rather different position is Kensington Chelsea and Westminster Health Authority, which has a dozen large independent hospitals and many minor clinics in its patch. And indeed, the reputation of the KCW registration and inspection system is much higher, with many of the hospitals they cover feeling that it is a more positive and worthwhile process. This helps confirm the benefits of moving in the direction proposed.

55. In looking at the proper terms of regulation for independent healthcare services, it is IHA's view that there must not be different standards of clinical care for independent healthcare and NHS care. The care standards should be national care standards that all patients can expect to be followed wherever they are treated. There are real differences between the public and independent sectors but the basic standard of care is not one of them. IHA is confident that member hospitals are delivering high standards of care, and a new regulatory system could make far more of a positive contribution to demonstrating it.

The process of regulation

56. There are two kinds of process problems with the Registered Homes Act. Some problems arise from the way the Act is implemented. Others arise because of the diminishing appropriateness of regulating a modern hospital as a nursing home with operating theatres.

57. With the multitude of local arrangements for inspection and regulation, there are sometimes inconsistencies in application, arbitrariness in standards and unnecessary bureaucracy. IHA has worked with the Department of Health and the Better Regulation Unit over time to make the existing system work as well as possible, and there have been improvements. The same problems do however continue to re-appear. A system with national agreed standards and co-ordination of inspection practice is widely seen as the way to resolve these issues.

58. The second category of problems arises because modern healthcare is less and less about long inpatient stays. The delivery of acute healthcare services are far more about organisations and professional staff than "bricks and mortar" hospitals, and that is what would be best regulated. With providers that range from small clinics to large groups of hospitals, regulations need make best use of the organisational structures. This will not be a "one size fits all" system. In a chain of 30 or 40 hospitals, an audit of the quality assurance systems may be more helpful than an attempt to build a parallel system to inspect each hospital. The ability to build a relationship with a national hospital organisation is another reason for organising regulation at a national level.

Summary: Acute Hospitals

59. In summary, the mainstream independent acute hospitals—IHA's hospital members—have a demonstrable commitment to high quality care. IHA is working with its members to implement systems of governance and accountability that deliver and demonstrate this.

60. The existing regulatory system needs to be reformed, to achieve a reasonable scale of operations, to recognise that hospitals are not just nursing homes, and to create a regulatory system that makes a positive contribution to quality of care.

61. The many other drivers of quality mean that the limitations of the Registered Homes Act do not undermine quality of care in mainstream independent hospitals. IHA does have concerns that there are sometimes situations where these other protections are not in place and where the Act does not apply, or fails to make a difference (see Section 4).

SECTION 3: MENTAL HEALTH AND SUBSTANCE MISUSE PROVIDERS

62. This Section builds on Section 2, drawing attention to issues specific to mental health. This section gives greater detail on the regulation, monitoring and inspection of independent sector mental health and substance misuse providers with inpatient facilities. Under the Registered Homes Act health authorities register and inspect them (on behalf of the Secretary of State) as "mental nursing homes". There is no regulatory concept of a "hospital".

63. There are obvious differences between mental health and acute medical/surgical provision in terms of appropriate staffing, treatments and facilities. Independent mental health providers have, in addition to registration requirements under the Registered Homes Act, an extra layer of regulation—the Mental Health Act and Commission. They are also different from independent sector acute medicine/surgery provision because a significant proportion of their services are purchased by the public sector. Health Authorities that purchase care from the sector, either on contract or more typically by spot purchasing—usually referred to as "ECRs"—include in the contract the right to monitor and inspect providers.

25 March 1999][Continued

Acute and Non-acute Care

64. The independent mental health sector can broadly be divided into two according to type of patient, length of stay and funding source: acute psychiatry and substance misuse treatment and non-acute psychiatric care. Acute psychiatry covers patients with acute psychiatric illness, length of stay is shorter than for non-acute psychiatric care and funding is either from private medical insurance (though many PMI policies exclude mental health cover) or increasingly from health authorities either on contract or spot purchased. Substance misuse services are also mostly spot-purchased by health and/or local authorities. Medium secure care is categorised here as acute care and usually spot purchased on "ECRs". Acute care is delivered in mental nursing homes though the term is misleading and these facilities are in reality psychiatric hospitals some with up to one 100 in-patient places or more.

65. Non-acute psychiatric care is usually not covered by PMI policies though other types of liability insurance may cover it. It includes brain injury rehabilitation, rehabilitation of the mentally ill, people with learning disabilities who have challenging behaviour and long term care of people with psychiatric disabilities. Funding comes largely from the NHS spot purchasing, income support or local authorities. In-patient stays are usually months or years as opposed to weeks or days in acute care.

66. Some services do not fit neatly into these categories of acute and non-acute care. Medium secure care is categorised as acute care in this submission however length of stay is often months. Substance misuse, adolescent psychiatry and treatment for eating disorders typically requires initially acute psychiatric treatment followed by non-acute care. Long-term care including care for the elderly mentally ill (EMI), and care for people with learning disabilities is provided in nursing and residential care homes. EMI services are not dealt with specifically in this evidence but further information on nursing homes is presented in Annex 3.

Overview of the Sector and Providers

67. According to Laing (1998) there are 73 independent hospitals or units in the UK providing acute psychiatric care and/or substance misuse inpatient treatment. Ten of these units are in independent hospitals also providing acute medical/surgical treatment. Laing (1998) estimates a total of 2,377 acute psychiatric or substance misuse beds (excluding medium secure) with a market value in 1997 of £94 million. Due to the significant numbers of substance misuse places registered by local authorities as care homes this figure underestimates the total number of residential substance misuse services.

68. There are 909 additional independent medium secure beds representing over 30 per cent of the UK's total medium secure provision. Partnerships in Care is the single largest provider of independent medium secure beds and provides 18.5 per cent of the total number of beds (including the NHS). St Andrew's hospital Northampton provides 7 per cent of the total number of medium secure beds available.

69. In the past few years the sector has diversified into specialist areas of provision such as eating disorders and adolescent psychiatry. For example, Laing (1998) reports that there are 31 independent sector specialist units treating eating disorders. Other significant niches of provision include low/medium secure care, 24-hour nursed care, and brain injury rehabilitation. Registered mental nursing homes provide 80.6 per cent (205 beds) of brain injury beds the NHS providing the rest. St Andrews, Partnerships in Care and Westminster Health Care between them provide the vast majority of services.

70. The three largest acute psychiatric providers (excluding medium secure care) Priory Hospitals, Charter Medical and Cygnet operate 41 per cent of the acute psychiatric sector's bed capacity. The next largest St Andrew's Group has 7 per cent of the market total.

71. The largest providers of non-acute psychiatric care including medium secure care are Partnerships in Care (the single largest provider) Westminster Health Care and St Andrew's Group. Excluding mental health beds for the EMI and acute psychiatry Laing (1998) estimates that 67 per cent of beds for non-acute psychiatric care are provided by independent registered nursing homes and residential care homes.

Employed Consultant Staff

72. More than acute medical/surgical hospitals, independent psychiatric hospitals often employ consultant staff, or have a mixture of employed, retained and self-employed consultants. An IHA survey found that the consultants employed either full-time or part-time in the independent mental health sector represented 11.5 per cent of all consultant psychiatrists in post. The number of consultant psychiatrists doing some work in the sector including those with admitting rights represents almost a quarter of all consultants in post.

*25 March 1999**[Continued]**Funding*

73. The vast majority of acute mental health care in the UK is provided and financed by the NHS or local authorities. Laing (1998) estimates that about 9 per cent of all acute psychiatric beds are provided by the independent sector: 6 per cent privately financed via self-pay or PMI and the remaining 3 per cent financed by the NHS. The NHS funds about 30 per cent of independent sector acute psychiatric beds. These are probably underestimates due to uncertainty about the numbers of acute NHS mental health beds and differences in classifying what constitutes acute (as opposed to non-acute) psychiatric care. Further, significant numbers of substance misuse providers are registered by local authorities as residential care homes. A report commissioned by the Department of Health and the IHA from the Sainsbury Centre for Mental Health (1995), now somewhat outdated, estimated then that 17 per cent of total acute provision was provided by the independent sector. Industry sources would put the figure as high as 20 per cent. The majority of long-term care for mental illness is financed by the NHS, local authority and/or income support.

Registration and Inspection

74. Like independent sector medical/surgical hospitals acute mental health and substance misuse services are registered and inspected by their local health authority registration unit according to the terms of the Registered Homes Act and associated regulations. A significant proportion of substance misuse services and long-term care services are registered by their local authority or dual registered. There are concerns about the appropriateness of registering residential substance misuse services and some long-term mental health care services as registered care homes with local authorities where a significant element of care is deemed health as opposed to social care.

75. HA registration officers make regular and increasingly more stringent inspections of registered nursing homes in their patch. Relations between providers and registration officers industry-wide are largely positive. However, qualified nursing and medical staff, consulted to inform this submission, who have experience of both the statutory and independent sectors report that the standards required of independent sector providers as a condition of registration are higher and often much higher than evident in the NHS and they vary from HA to HA. They also report that the focus of inspections and the composition of the inspection team in terms of relevant qualifications are often inappropriate. There is frequently an undue emphasis on hotel standards such as décor and not sufficient emphasis or psychiatric expertise into inspecting standards of treatment and care.

76. For example substance misuse providers report registration officers are not sufficiently informed about quality standards of treatment and therapy. The appropriateness of referral and indeed acceptance of the referral by the provider is not monitored. Acute psychiatric providers report that the failure of health and local authority purchasers to fulfil their obligations under section 117 of the Mental Health Act requiring their input into pre-discharge planning is known but persistently not corrected. Hotel standards (eg furnishings and decoration) are expected to be much higher in the independent sector than in equivalent units in the NHS.

77. Overall there is a general feeling that the registration and inspection process could be improved. It should be more relevant to care and treatment standards and these standards should be explicit and capable of systematic audit. The registration team needs to be sufficiently expert in terms of qualifications and experience. Providers themselves from other similar hospitals (independent and statutory) could make a useful contribution to inspections and be invited to join inspection teams, as could assessors from the Royal College Psychiatrists. Standards should be consistent across the UK and the same standards that are expected of the independent sector should also be required and monitored in the statutory sector.

78. The principle that public sector funded patients should expect and receive the same standards of care and treatment irrespective of geographical location or provider sector (statutory or independent) should be built into the statutory registration and inspection process.

Mental Health Act 1983 and Commission

79. Under the Registered Homes Act 1984 mental nursing homes may only detain patients under the Mental Health Act 1983 if specifically registered to do so they must then comply with all the provisions of the Act. The commission has a statutory duty to visit detained patients in registered mental nursing homes. The Mental Health Act Commission reports the total number of beds and admissions to independent sector providers as increasing. Providers range from large hospitals providing medium secure care to small homes where there may be only one or two patients detained under the Act (MHAC, Seventh Biennial Report 1995–97, HMSO, 1997)

80. Each registered mental nursing home receives a Full Visit and at least three Patient Focused Visits in a two-year period, with medium secure units at least one a year. As part of the Patient Focused Visit, Commission members collect information in a standardised format on key issues. Additionally, targeted visits

25 March 1999][Continued

are undertaken to examine specific issues, which may be a matter of particular interest. Targeted and Patient Focused Visits may be unannounced or at short notice. Reports from visits are sent to the providers and the registering health authority. The Commission also publishes a Biennial Report documenting its findings from visits including naming units exhibiting good and bad practice.

81. The Commission has stated a particular interest in independent sector medium secure units because of their size and significance. Kneesworth House, Stockton Hall, Llanarth Court, Redford Lodge (all four operated by Partnerships in Care) and St Andrew's Northampton are frequently inspected by the Mental Health Act Commission.

82. Relations between the Mental Health Act Commission and independent sector providers are very good. The sector as a whole welcomes the diligence and expertise of the Commission and finds its reports and recommendations for service development and improvement helpful. Sector representatives in membership of the IHA meet formally at least once a year with representatives of the Commission to discuss developments. Despite its role as an inspectorate, the Commission is experienced by the sector as accessible, informative, and conducive to service developments and improvements.

83. The Mental Health Act 1983 is currently under review. Independent sector providers individually and through the IHA are in contact with the review team. The IHA mental health division is running an industry-wide consultation on the scope of the review issued by the review team and to be submitted by the end of January 1999.

Regulation by purchasers

84. Registered mental nursing homes are also subject to monitoring and inspection by the statutory purchasers of care. Purchasers usually provide for this with clauses in their contracts. In practice only purchasers with a significant financial investment in a particular unit will visit, inspect and monitor the provider. Typically, several different health and/or local authorities will fund patients in a registered acute or non-acute mental nursing home. Organisations providing exclusively substance misuse services report that inspection and monitoring by statutory contractors is negligible.

85. The Commission drew attention in its Sixth Biennial Report to its concerns about the lack of monitoring and inspection by purchasers of medium secure care. Places are purchased in these units by large numbers of HAs. A lead purchaser arrangement to undertake monitoring at a particular hospital on behalf of all the other purchasers has been put in place by the NHS. This arrangement has not been entirely successful. As a result providers have developed and put in place service level agreements with purchasers.

86. In July 1998 the government published *Commissioning Specialised Services*, which proposes the setting up of regional specialised commissioning groups. Regional offices of the NHS are to take responsibility for ensuring that effective arrangements are in place for commissioning specialised services and setting up commissioning groups. The definition of specialised services includes services where there are frequent referrals to the sector including medium secure care, brain injury rehabilitation, treatment for eating disorders, and in-patient child and adolescent psychiatry. The sector is awaiting further guidance and information. The role of the new groups in regulating and inspecting services is unknown. There is a strongly held view amongst independent providers that these groups preferably via representation on the group should formally consult them.

87. Private medical insurers are increasingly getting involved in the monitoring of care they purchase. By the end of the 1980s medical insurers were targeting psychiatric care as a speciality particularly amenable to cost containment through managed care initiatives. Pre-authorisation and utilisation reviews are standard practice. The introduction of provider networks and treatment protocols in the 1990s continue the process of cost-containment through monitoring and regulation of care.

The Government's Mental Health Strategy

88. The absence of formal processes and requirements on the part of the NHS to include the sector in the planning, development, and provision of mental health services, including specialised services, is of considerable concern to providers. *Modernising Mental Health Services* the government's mental health strategy published in December 1998 makes no mention of the independent sector beyond para. 4.59 which refers only to the importance of working in partnership with the voluntary and charitable sector. In the light of the information provided in this submission about the range and volume of mental health care provided by the independent sector, particularly in the areas highlighted for development in the strategy such as secure, acute and 24-hour nursed care, the sector wishes to have a greater input into policy development and planning.

89. The status of the sector with respect to the government's recently announced quality and clinical governance framework is also unknown. The relationship between independent sector mental health providers and the National Institute for Clinical Excellence (NICE), National Service Framework (NSF) and

*25 March 1999]**[Continued]*

Commission for Health Improvement (CHI) is unknown. The publication of the mental health NSF is expected in April. The sector was not granted representation on the government's external reference group that devised the mental health strategy nor any of its numerous sub-groups. Similarly the sector was not granted consultation with the body appointed under Professor Thornicroft developing the NSF. In future the sector would like to be more closely involved with planning and policy development bodies.

90. The sector welcomes the government's national quality standards initiatives. The view of the sector is that independent mental health providers should be acknowledged for the significance of their contribution and included, in the same manner as NHS and local authority providers, in the new quality of care standards framework currently being set up.

Self-regulation

91. Independent mental health and substance misuse treatment providers in membership of the IHA have developed and implemented a considerable number of quality assurance initiatives. All IHA mental health members are required as a condition of membership each year to sign up to the IHA's quality assurance policy which requires members to participate in an IHA approved quality assurance scheme. For approval schemes have to be externally operated, credible, whole hospital and directed at service quality. Schemes approved include King's Fund *Health Quality Service*, ISO9000 series, EATA *Towards Standards for Drug and Alcohol Services*, and (once fully developed) the Health Advisory Service 2000. Members are also required to sign up to the IHA's Code of Practice for Psychiatry and Substance Misuse Membership (see Annex 8).

92. Representatives of all the sections of the Royal College Psychiatrists meet with representatives of the IHA mental health membership on a regular basis through the RCPsych/IHA Liaison Group set up in 1995. The group is chaired by the Registrar of the College. The focus of the group is quality standards. Joint initiatives to date include manpower and training standards surveys, a consultant appointment process for posts in the independent sector, confidentiality and discharge guidelines for providers of care for the EMI, series of papers focusing on quality issues at the interface of the independent sector and NHS covering to date, EMI, forensic psychiatry and psychotherapy.

Patient Complaints

93. The IHA approved quality assurance schemes and code of practice include best practice with respect to complaint policies and procedures, which will be boosted by the revision of the Code of Practice on Patient Complaints. Providers treating NHS funded patients are also subject to the complaints handling requirements and procedures of their statutory purchasers including ultimately access to the NHS Ombudsman for NHS funded patients.

Summary: Mental Health

94. The independent mental health and substance misuse sector is a sizeable and growing contributor to acute and non-acute mental health services in the UK.

95. Independent providers of mental health and substance misuse provision welcome inspection and regulation and view it as a valuable process in enhancing the quality of patient care. The sector is already heavily regulated, more so than equivalent services in the statutory sector. Current regulation by registering IHAs is variable and patchy. Registration teams are frequently insufficiently expert and focus on facilities as opposed to treatment and care.

96. The status of the sector with respect to the government's newly announced clinical governance framework and mental health strategy is unknown. The sector would like to be more closely involved with the planning and consultative bodies set up to devise the latest mental health policies.

97. The sector welcomes the Mental Health Act Review and continues to operate productively under the Mental Health Act Commission.

98. The principle of equity of regulation for providers of similar services across the NHS and independent sectors should apply for the benefit of patients.

SECTION 4: UNREGULATED PROVIDERS

99. Statutory regulation is but one of the many drivers of high quality care in mainstream independent hospitals, and by no means the most important one. There are providers—such as hospitals incorporated by Royal Charter—that share the commitment to quality of care of other hospitals but are exempt from the Registered Homes Act. There are other providers—some indeed registered and inspected under the Act—

25 March 1999][Continued

that are the cause of widespread concern in the sector. When the other drivers of quality are missing, the role of the Registered Homes Act or other regulation is more important. While it is not effective as a guarantee of high quality care, the Act does set the entry level.

100. In addition to improving the quality of the regulatory system, IHA views it as essential that its coverage is expanded to include healthcare providers that currently escape it. As Exhibit 2 makes clear, there are a number of types of provider that are not covered by direct regulation. Areas that cause particular concern to IHA and its members include:

- NHS Private Patient facilities;
- Cosmetic surgery;
- Other minor surgery in unregulated premises;
- Isolated professional practice;
- Substance misuse clinics registered only as residential homes;
- Private ambulances.

IHA is also aware that others organisations have raised concerns about private general practice. IHA has not looked in detail into the issues, but is very supportive of the development of independent primary care, so long as the right quality assurance is in place.

NHS Private Patient facilities

101. NHS Private Patient Facilities slip through a gap in regulation. They are unregulated. Independent hospitals are regulated under the Registered Homes Act. The NHS regulates Trusts through the commissioning process, and the NHS White Paper has proposed a more formal system. Paybed units also get a lesser proportion of their patients from medical insurers, whose influence is correspondingly less. It is IHA's strongly held view that NHS paybed units, if they are to exist at all, must face proper regulation.

Cosmetic Surgery

102. There is much cosmetic surgery that is successful, beneficial and appropriate. The independent sector provides substantial volumes of reconstructive surgery, as well as operations chosen to enhance appearance. Problems can arise when some of the other quality are missing. In some cosmetic surgery:

- GPs are often not involved in choosing which surgeon operates, or where;
- Surgery is often self-funded, so there is not usually a medical insurer providing oversight;
- Surgery performed in premises "primarily" used for professional consultations is not subject to registration under the Registered Homes Act.
- There are no objectively defined professional rules to specify who may perform cosmetic surgery (or any other type of surgery).

103. This is in contrast to a typical mainstream independent hospital operation, which will be:

- performed by a consultant who was chosen by the patients GP,
- paid for by an insurance company who will monitor the hospital and consultant,
- performed in a regulated hospital,
- where the surgeon has been assessed by the Medical Advisory Committee.

Surgery in consulting rooms and GP premises

104. Similar concerns can arise with minor surgery performed in consulting rooms or GP's premises. It is anomalous that the same procedure is regulated when performed in a purpose built hospital operating theatre, but need not be when performed in less than ideal circumstances. IHA also understands that GP minor surgery in the NHS has been a cause of concern to some NHS consultant surgeons.

Isolated professional practice

105. The General Medical Council, UKCC, or similar bodies regulate clinical professionals, but not, except when the subject of complaint, their professional consulting practice. There is no automatic requirement for a clinical professional to be part of a wider community of professions for audit, review and oversight. This creates a potential weak spot in regulation. A theoretical weakness becomes a major cause for concern when the professions are unregulated, such as is the case for many complementary practitioners.

25 March 1999]

[Continued

106. Practitioners who have privileges at an independent hospital, or work in the NHS will be part of a clinical community, and can be regulated and monitored through the provider organisations. IHA however takes the view that there should be a system that ensures that no practitioner works entirely on their own, but instead are visible to their colleagues.

107. Including all professional clinical practice in a system of regulation is a large project. With healthcare becoming less and less based around hospitals and more and more around mobile and home-based care, this is an issue that will, if avoided now, cause problems in the near future. Further, the growth of use of complementary medicine has opened a broad set of regulatory questions that need to be answered.

Substance misuse clinics registered only as care homes

108. Many substance misuse clinics are not in fact registered as nursing homes, let alone mental nursing homes, but are only registered as residential homes by a local authority. This means that there is no regulatory oversight of the medical aspects of care there. The process of treatment is not without medical risk.

Private ambulances

109. Private ambulances also are not regulated. Even well informed independent hospitals can find it hard to get objective information about the standards and quality of provision. Extending healthcare regulation to cover private ambulance services would help bring order to this market, and be consistent with the wider principles IHA proposes.

110. Indeed, IHA would argue that all kinds of provision should be brought under the regulatory umbrella, except where an explicit and definite case has been made for exemption. The grounds for exemption must be of clear benefit to patients, not administrative convenience or dogma.

SECTION 5: OPTIONS FOR REGULATORY REFORM

111. IHA is strongly of the opinion that acute healthcare regulation does need to be reformed. This section seeks to draw together some overall conclusions about the regulation of independent healthcare that would present a way forward from the present position.

112. There are many drivers of quality in an independent acute or psychiatric hospital that help secure high quality care, of which regulation is just one. At present some regulatory systems, such as the Mental Health Act system seem to be making a positive contribution. In contrast the Registered Homes Act is making only a marginal contribution.

Principles for new regulations

113. Some general principles that a new regulatory system should follow can be set out. There are a great many ways that new regulations could be implemented. IHA would assess any new system against the kind of principles set out below.

114. Fitness for purpose: IHA sees the purpose of regulation as protecting patients while enhancing their rights and access to care.

115. Full coverage of healthcare: IHA believes that all healthcare providers—including the public sector—should be regulated. Any exemptions must be positively justified. At present borderline cases are excluded from effective regulation, and are the major sources of concerns about quality of care.

116. Outcome focused: Regulation must focus on the outcomes of clinical care. The delivery of those standards is essentially a matter for the management and staff of the healthcare provider. The current system, with a focus on inputs, confuses the roles of manager and regulator.

117. Culturally oriented towards healthcare: Healthcare is a very—perhaps uniquely—complex and specialised sector. It is difficult to regulate healthcare effectively unless the regulatory culture is oriented towards healthcare. The approach and instincts of the regional Commissions for Care Standards would be very different and less appropriate for hospitals than, for example, those of NICE or the Royal Medical Colleges.

118. Light of touch: Regulation is but one driver for quality in healthcare, and at times a blunt instrument. IHA has worked with the Department of Health, the Better Regulation Unit and others to make the existing regulation effective and light of touch. A new system should have this designed in from the start. Rather than building a parallel system, a model that reviews and tests an organisation's or a profession's own quality assurance processes can produce greater effectiveness at lower cost.

25 March 1999]

[Continued

119. Regulate organisations and people: The subjects of regulation now are the premises used to deliver services. This is inappropriate. The organisations and the clinical staff are the most important components of a modern healthcare delivery system. Such an arrangement is more flexible and adaptable. For example the healthcare components of a nursing homes or residential care environment can be regulated in the same way as any other healthcare services. Of course for this to work the necessary systems—for example to perform police record checks on staff—must be in place.

120. Integration for clinical quality standards and good practice: Clinical quality standards and good practice must be national quality standards and good practice, not NHS or independent sector standards and practice. At the level of basic systems, standards of care, professional qualifications, the reporting of adverse incidents, and so on, there is no justification for not integrating the NHS and the independent sector. Integration at this level will facilitate audit and monitoring in both sectors, and provide benchmarks for both sectors to work towards. It will also facilitate contracting between the sectors, which is an important consideration in some service areas.

121. Differentiation of management and finance: While the systems that support quality of care should be common to both sectors, the NHS and independent sectors are not the same. Indeed there are differences between them that go to the very heart of what differentiates independent and NHS healthcare. It would be wholly inappropriate, for example, to have common systems for priority setting, resource allocation, or capital planning. This does not prevent organisations sharing information or agreeing to work as partners. Indeed it is often these very differences that make partnership beneficial to both.

Practical regulatory options

122. In looking for practical regulatory options, the current policy context is important. IHA sees four main potential locations for independent health care regulation:

- NICE and CHI, as described in *The New NHS: Modern, Dependable*;
- A new national independent regulatory, or self-regulatory body;
- “The Frankenstein Option”, built from the remains of the Registered Home Act 1984;
- Commissions for Care Standards, as described in *Modernising Social Services*.

Of these IHA would prefer the first, and sees the second as broadly acceptable. IHA’s view is that only these two of the four options will produce a system that makes regulation a positive contributor to quality of care. Of course, the actual implementation also has to be right.

123. NICE and CHI are in effect, the new regulators for the NHS, and address the same problems of setting clinical standards and detecting problems early. IHA does not believe that the UK need two parallel systems for governing healthcare providers; instead there should be one system that is flexible enough to cope with and learn from the full range of UK providers.

124. A parallel national regulatory system to the NHS’s would be inefficient, and if either were doing their job properly would choose to co-operate extensively. While a separate independent sector regulator would lose some of the benefits of scale, the regulation of 300 hospitals, numerous clinics and thousands of practitioners is a worthwhile task for a national body. It is hard to see justifications for not combining the independent and NHS systems that would not also suggest that such a body should involve a substantial degree of industry self-regulation.

125. The current statute might, driven to its limits, be turned into something more workable. For example, the Secretary of State has powers to make regulations under the Registered Homes Act to exempt specified classes of provider from regulation, which provides a window for opting out to self-regulation with the agreement of the Department of Health. But an approach that built a new system from the fragments of the current Registered Homes Act 1984 once social care and nursing homes have been taken out of it would almost certainly be expensive, inefficient and prone to failure.

126. The proposals in *Modernising Social Services* aim to produce a coherent system of social services regulation. Bolting hospitals onto that system would produce an incoherent combination of systems. Culturally a combined nursing and residential care home regulator would be less appropriate to hospitals than the current health authority based system. Also, operating at a regional level would still leave each region, especially outside the South East of England, with too few units to reach a reasonable level of expertise and efficiency.

127. As mentioned in Section 2, IHA supports expanding the remit of the Health Service Commissioner to cover all healthcare, independent or public. At present the NHS Ombudsman’s remit includes only healthcare purchased by the NHS from the independent sector. In line with suggestions from patient and consumer groups, independent hospitals would be entirely happy to have all healthcare, whether NHS purchased or not, covered by the Health Service Commissioner’s investigations. IHA is confident that such rigorous

*25 March 1999]**[Continued*

independent scrutiny would not harm but rather benefit the independent sector's reputation and could provide an additional layer over and above the sector's own complaints handling and independent review procedures.

Next Steps

128. IHA is optimistic that this timely inquiry will help settle the government's policy on the regulation of independent healthcare, and lead to increased recognition of the important role independent healthcare has to play in the UK's healthcare system. IHA wants to see a coherent regulatory system that covers all types of healthcare providers and focuses on clinical outcomes, while protecting consumers from sub-standard practice in areas currently outside of direct regulation. IHA will continue to work for these changes.

January 1999

Supplementary memorandum by Independent Healthcare Association

PRIVATE PRACTICE FORUM (PM 58A)

PRINCIPLES FOR A PRIVATE MEDICINE CLINICAL QUALITY FRAMEWORK

For each independent hospital, clinic or pay-bed unit:

- The Hospital General Manager is accountable overall for quality and risk management.
- There will be a Medical Advisory Committee (MAC) which should include representation of each speciality working at the hospital.
- The General Manager, MAC and designated consultant (see below) should agree a documented clinical governance framework which will provide the constitutional basis for developing a clinical quality strategy (see below).
- A designated consultant (often the MAC Chairman) will take responsibility for delivering (with the support of the other clinical professional "heads"), reporting on and evaluating the documented clinical quality strategy, involving and covering all clinical staff and departments.
- There must be 24-hour on site RMO cover for in-patients, all RMOs having advanced life support training and certification and relevant clinical experience. Free-standing day-case centres should have appropriate medical cover in working hours, with arrangements to deal with out of hours emergencies.
- Where present, an ITU and/or HDU (as defined using nationally accepted criteria) has relevant on-site specialist medical cover when in use, under the supervision of an appropriate intensivist/anaesthetist.
- There must be a properly constituted and administered clinical complaints procedure.
- There must be maintenance of adequate clinical records (including medical component).
- Current organisational quality standards, externally verified will be held (eg HQS, ISO, EQM or HAP).

DESIGNATED CONSULTANT WORKING WITH THE MAC)

Will take responsibility to:

- Develop and ensure delivery and evaluation of Clinical Quality Strategy to include:
 - clinical risk management programme
 - clinical audit
 - measurement of clinical outcomes
 - formal procedures for the review of clinical competence
 - clinical education, training and professional development
 - prompt analysis of untoward clinical incidents and clinical complaints
 - integration with wider quality programmes within the hospital
 - annual report on clinical quality
- Ensure maintenance of agreed standards in relation to proper clinical notes and consent forms, and ethical committee approval for research studies.

*25 March 1999]**[Continued]*

- Liaise with counterparts in other local hospital/units, particularly where there may be concern about the activities of a consultant in relation to patient safety or professional conduct. Where there is evidence that patient safety may be threatened, there is a duty to inform local hospitals/units (preferably doctor to doctor) and medical directors of major insurers. Reciprocal arrangements should also apply.

MEDICAL ADVISORY COMMITTEE (AND SPECIALTY GROUPS)

- Advise the Hospital General Manager on practice privileges (including scope), having taken specialty specific advice and/or having followed formal clinical competence review procedures as appropriate.
- Regular review of clinical information, including:
 - all deaths
 - unplanned re-admissions, re-operations and transfers to other hospitals/units
 - infection control data
 - unexpectedly long lengths of stay
 - out of licence use of drugs
 - untoward incidents
- Support development of local good practice standards (clinical guidelines) and multi-disciplinary care pathways—preferably based on national/evidence based guidelines.
- Agree priorities and protocols for clinical audit and outcome measurement, support and facilitate regular clinical audit in each specialty and disseminate written records of such audit within each specialty and to the designated consultant.

EACH DOCTOR

- Medical practice privileges contingent on:
 - NHS consultant status (or equivalent)
 - adherence to GMC or GDC good practice guidelines
 - evidence of Hepatitis B immune status as advised by Department of Health
 - maintenance of appropriate professional indemnity at all times
 - adherence to hospital health and safety policies
 - participation in hospital complaints procedure
 - health status appropriate for clinical practice

Also required:

- active participation in clinic audit—including relevant National Confidential Enquiries
- participation in continuous professional development
- three year review of professional development plans
- All patients undergoing procedures to give valid, informed consent, following discussion with clinician conducting the procedure, in accordance with agreed hospital policy.

Insurers

Except for reasons of urgency, clinical complexity and/or geographical access (for individual patients) insurers will seek to avoid contracting with hospitals failing to meet at least the standards set out in the Framework from 1 January 2000.

Timetable

- Uncompleted stages of Framework to be implemented from 1 February 1999.
- Target for full implementation—1 January 2000.

[Continued]

1.	The Independent Sector	...	...	...	...	...	...	...	...
1.1	The Independent sectors contribution to health care	...	...	...	...	...	...	...	...
1.2	Why statutory regulation?	...	...	...	...	...	...	...	...
1.3	The purpose and benefits of health care regulation ...	...	...	...	...	...	...	...	...
2.	BUPA's support for statutory regulation	...	...	...	...	...	...	...	...
2.1	Shared benefits and risks	...	...	...	...	...	...	...	...
2.2	Encourage transparency, accountability and consistency	...	...	...	...	...	...	...	...
2.3	Flexible, practical and realistic regulation	...	...	...	...	...	...	...	...
2.4	Broader regulation and equal standards	...	...	...	...	...	...	...	...
2.5	Closer relationships with the NHS	...	...	...	...	...	...	...	...
3.	Quality and performance management	...	...	...	...	...	...	...	...
3.1	Setting clinical standards	...	...	...	...	...	...	...	...
3.2	Providing quality health care ...	...	...	...	...	...	...	...	...
3.3	Purchasing quality health care on behalf of patients	...	...	...	...	...	...	...	...
3.4	Quality frameworks for the independent sector	...	...	...	...	...	...	...	...
3.5	BMA Private Practice Committee report	...	...	...	...	...	...	...	...
3.6	Health and social regulation	...	...	...	...	...	...	...	...
3.7	The Independent Hospitals Association (IHA)	...	...	...	...	...	...	...	...
4.	Expanding the scope of regulation and monitoring	...	...	...	...	...	...	...	...
4.1	What is currently regulated?	...	...	...	...	...	...	...	...
4.2	Why the review should extend current regulation	...	...	...	...	...	...	...	...
5.	Regulating premises and people	...	...	...	...	...	...	...	...
5.1	The focus of regulation	...	...	...	...	...	...	...	...
5.2	The terms of regulation	...	...	...	...	...	...	...	...
5.3	Benchmark standards ...	...	...	...	...	...	...	...	...
6.	Other issues	...	...	...	...	...	...	...	...
6.1	Assuring the standards of independent medical practice	...	...	...	...	...	...	...	...
6.2	Co-ordinating information	...	...	...	...	...	...	...	...
6.3	Complaints procedure...	...	...	...	...	...	...	...	...
6.4	The regulation of "non-acute" nursing homes	...	...	...	...	...	...	...	...
7.	Options for the regulation, monitoring and inspection of health care outside the NHS	...	...	...	...	...	...	...	...
7.1	Removing the requirement for regulation or maintaining the status quo ...	...	...	...	...	...	...	...	...
7.2	Other options	...	...	...	...	...	...	...	...
7.3	Extending the terms of reference of the Regional Commissions for Care Services	...	...	...	...	...	...	...	...
7.4	Extending the terms of reference of the Commissions for Health Improvement and delegating some responsibility to Regional Offices and the Royal Colleges	...	...	...	...	...	...	...	...
7.5	Creating a new national statutory body, accountable to the Secretary of State for Health, responsible for regulating the independent health care sector, perhaps with delegated powers to industry representative bodies...	...	...	...	...	...	...	...	...
7.6	BUPA's preferred option	...	...	...	...	...	...	...	...

25 March 1999]

[Continued

CONCLUSIONS AND SUMMARY

BUPA welcomes this Inquiry as a timely opportunity to develop universal standards which will improve the quality of care for patients.

BUPA believes that the NHS and the independent sector should be regulated and monitored on broadly the same basis. Benefiting and protecting patients should be the focus for any regulatory framework. Patients must be confident that they are receiving care which is:

- Evidence based
- Provided to agreed standards in both the NHS and the independent sector.

This will result in a seamless service which will optimise the use of the combined resources of the NHS and independent sector and will encourage collaboration between the two where appropriate.

1. The advantages of regulating and monitoring the independent health care sector on broadly the same basis as the NHS are:

- The best possible quality of care and protection for patients;
- Health care based on the same set of agreed standards in both the NHS and the independent sector;
- Opportunities to share information between the NHS and the independent sector about best practice, activity and performance for the purpose of clinical audit and outcome (results and benefits for patients) monitoring;
- Direct and meaningful comparisons between the sectors;
- Ensuring that practitioners have the capacity and capability to meet their responsibilities;
- Opportunities for collaboration.

In addition, patients could benefit significantly from the creation of electronic health care records, which combine both NHS and independent health provider records. *Ref: Paras 1.3, 2.4*

2. BUPA's view is that all health care should be evidence based and subject to regulation by external monitoring, scrutiny and evaluation of its risks and benefits. This should include:

- The entire range of medical practice;
- Care and treatment provided by dentists, opticians, dispensing pharmacists, osteopaths, midwives, nurses, physiotherapists and other professions allied to medicine;
- Complementary or alternative practitioners;
- Immunisation, screening and occupational health services.

The onus of justifying exemptions from regulation should lie with each profession or discipline.

The most important test of health care is appropriate outcomes (the results and benefits for patients) of care and treatments. The necessary evidence base to support such regulation does not presently exist. The process of researching and evaluating such practices in order to create the necessary knowledge should therefore be accelerated. *Ref: paras 3.1, 4.1, 4.2, 5.1*

3. Two primary subjects of regulation are required: premises and people, particularly but not exclusively the health care practitioners responsible for care and treatment. There should be clarification of the regulatory role in ensuring the quality of care and appropriateness of those persons involved. *Ref: para 5.1*

4. It would be helpful if the General Medical Council (GMC) issued guidance that entry onto the GMC specialist register should be the minimum criterion for conducting independent practice in the relevant speciality. Periodic revalidation of fitness to remain on the specialist register is also necessary. *Ref: para 6.1*

5. There should be an external complaints procedure which embraces the NHS and the independent sector. The Health Ombudsman might take this role. *Ref: para 6.3*

6. BUPA is content with the proposed regulatory framework for "non-acute" nursing home and residential care services set out in the Government White Paper "Modernising Social Services" and would welcome the establishment of Regional Commissions for Care Standards. However, we do have considerable reservations about the standards proposed by the Centre for Policy on Ageing. BUPA has offered an alternative set of standards to The Royal Commission on Long Term Care. *Ref: para 6.4*

7. We support the principles and policy objectives of regulation that have been set out by the Government's Better Regulation Task Force.

Our preferred structural option for the regulation of the independent health care sector would be to extend the terms of reference of the Commission for Health Improvement and delegate some responsibility to NHS Executive regional offices and the Royal Colleges. This option would improve the quality and safety of health care for patients by:

- Introducing common measurable standards across the NHS and the independent sector which would facilitate effective collaboration and a seamless service for patients;

25 March 1999][Continued

- Maximising information sharing;
- Introducing more effective monitoring;
- Offering the greatest flexibility;
- Consolidating and complementing existing arrangements;
- Providing a practical framework for the implementation of such regulation.

Such regulation should be practical and cost effective to implement. Its focus should be the maintenance and improvement of quality health care and not as a mechanism for apportioning blame. *Ref: paras 2.2, 2.3, 7.2-7.6*

BUPA is happy to provide additional evidence to support any of the issues raised in this document.

1. THE INDEPENDENT SECTOR

1.1 *The Independent Sector's contribution to health care*

The independent health care sector makes a significant contribution to health care in this country. One million people receive inpatient treatment in independent hospitals each year. The independent sector is responsible for 20 per cent of all planned operations (non-emergency) which would otherwise cost the Government between £500 million—£1 billion (assuming capacity was available) each year and would significantly increase NHS waiting lists.

1.2 *Why statutory regulation?*

Statutory regulation would command greatest public confidence and is likely to be more binding and effective than a voluntary system.

Such regulation should:

- Ensure patients receive the best possible care and treatment;
- Facilitate continual development and improvement of health care standards;
- Command public confidence;
- Satisfy public expectations that agreed standards are being consistently met;
- Be clearly understood;
- Be cost effective and practical to implement;
- Be flexible enough to adapt to changing demands and patterns of health care delivery;
- Not restrict the freedom to trade.

1.3 *The purpose and benefits of health care regulation*

We believe the main purpose of statutory regulation is to provide a clear and concise set of rules and guidelines that ensure the safe and effective management and delivery of health care.

2. BUPA'S SUPPORT FOR STATUTORY REGULATION

The provision of health care is becoming increasingly complex. The Government should therefore assure the quality of all health care services if it is to discharge fully its responsibility to protect and promote the health of the nation.

BUPA welcomes the opportunity to fundamentally re-appraise the regulation, monitoring and inspection of non-NHS health care, for the following reasons:

2.1 *Shared benefits and risks*

The emergence of new technologies, improved drugs, surgical techniques and therapies lead to greater benefits and risks.

Events during the past year have highlighted the inadequacy of current regulatory arrangements for conventional medicine and surgery in both the public and independent health care sectors.

*25 March 1999]**[Continued]**2.2 Encourage transparency, accountability and consistency*

BUPA wholly supports the principles and policy objectives of regulation set out by the Government's Better Regulation Task Force to encourage transparency, accountability, targeting, proportionality and consistency. Statutory regulation of health care should benefit and protect patients, staff and the public and in particular:

- Ensure that all health care-related risks are being managed effectively and that appropriate operational policies and records are developed and maintained;
- Ensure that effective and appropriate therapies are being employed and that the effects and impact of such therapies are being systematically recorded and evaluated;
- Promote the dissemination of best practice but clearly distinguish between "requirements" (which must be implemented) and "aspirational" suggestions;
- Improve the quality of health care by working to agreed standards as well as shared learning and information;
- Protect freedom of choice and equity.

2.3 Flexible, practical and realistic regulation

A regulatory system must be sufficiently flexible to promote innovation and adapt to changing needs. This will only be achieved through practical and realistic proposals that acknowledge the limits of regulation and do not restrict freedom to trade or consumer choice.

2.4 Broader regulation and equal standards

BUPA thinks an opportunity therefore exists to broaden the scope of current regulation and set equal standards across the independent sector and the NHS in order to benefit patients by:

- Ensuring patients receive all health care based on the same set of agreed standards in both the NHS and the independent sector;
- Improving the quality of care for patients, in all health care settings;
- Creating regulatory equality between the independent sector and the NHS;
- Maximising the opportunities to share knowledge and information about patients, best practice and activities;
- Making direct and meaningful comparisons between the sectors;
- Ensuring that practitioners have the capacity and capability to meet their responsibilities.

2.5 Closer relationships with the NHS

This Inquiry is a timely opportunity to develop closer working relationships with the NHS. BUPA believes that closer collaboration will result in better and safer care for patients.

3. QUALITY AND PERFORMANCE MANAGEMENT

In 1998 the Government announced detailed plans to manage more closely the performance and quality of services provided by and to the NHS. BUPA supported these plans by making commitments (in public and to the Government) to match these standards by implementing parallel systems. Our responses to these plans are described below.

3.1 Setting clinical standards—guidelines, methods and information

The Department of Health document "A First Class Service" suggests that NICE should produce and disseminate:

- clinical guidelines based on relevant evidence of clinical and cost-effectiveness; and
- associated clinical audit methodologies and information on good practice.

NICE will therefore be instrumental in setting clinical standards. These are currently only intended to cover the NHS. BUPA believes that in order to achieve equal standards across both sectors NICE should also include the independent sector.

BUPA and the BUPA foundation already provides funding for the work of a number of UK academics who research and promote evidence-based health care including Sir Michael Peckham at University College, London and Dr Muir Gray and Prof David Sackett at Oxford University.

25 March 1999][Continued

3.2 *Providing quality health care*

“A First Class Service” proposed a coherent and increasingly comprehensive framework for health care standard setting, to assure and evaluate the quality of services. BUPA has responded by preparing a revised Clinical Services Strategy, setting out new local requirements—see Annex B (pages 25–27)²—and building on a series of quality assurance and improvement initiatives undertaken by BUPA Hospitals over the past five years—see Annex C (pages 28–33).

3.3 *Purchasing quality health care on behalf of patients*

BUPA spends more than £600 million per annum on health care, for its private medical insurance (PMI) members. Examples of BUPA’s initiatives are summarised in Annex D (pages 34–35).

PMI purchasers of care also play a legitimate role in setting and improving quality standards. This is achieved through the contracting process—which includes the setting and agreeing of minimum standards with those hospitals who care for PMI members.

3.4 *Quality frameworks for the independent sector*

In October the Private Practice Forum of the Academy of Royal Colleges asked BUPA’s Group Medical Director to coordinate the development of a “private medicine clinical quality framework” that should become the benchmark for medical practice in hospitals and clinics across the sector from 1 January 2000. This framework complements BMA proposals and also considers issues of responsibility at the level of each “facility” (hospitals and clinics). The Academy of Royal Colleges aims to submit its framework to the Inquiry on 27 January 1999.

3.5 *BMA Private Practice Committee report*

In 1997 the BMA established a Private Practice Committee (PPC) which has prepared a wide ranging discussion paper about developing systems for Clinical Governance in independent health care.

BUPA supports the PPC proposals, which have been discussed with the BMA and which, we understand, have been submitted as part of the BMA’s evidence for the Inquiry.

The BMA PPC recommendations are designed to ensure that:

- There are mechanisms in the independent sector to monitor practitioners and facilities in a similar fashion to the NHS;
- Specialists working outside formal hospitals structures should be accountable, perhaps through local independent hospital Medical Advisory Committees (MACs);
- MAC chairmen in independent hospitals should fulfil a similar role to that of medical directors of NHS Trusts in relation to local professional self-regulation;
- A formal procedure exists for patients to pursue complaints about the clinical care they receive which is at least as rigorous as in the NHS;
- There should be agreed arbitration procedures for non-clinical complaints which are open for use by all parties;
- Private medical facilities and laboratories should be subject to inspection as rigorous as those undertaken at NHS hospitals;
- There should be national standards and a similar inspection regime for NHS pay bed units;
- Where doctors in independent medical practice have concerns about the performance of colleagues, they should have a professional and moral responsibility to bring the matter formally to the attention of other colleagues.

The BMA has proposed a range of procedures to investigate and resolve all types of performance issues (which MAC chairmen should ensure are in place).

3.6 *Health and social regulation*

In December the Government announced plans to establish Regional Commissions for Care Services to improve and increase the regulation of social care provision, currently inspected by DHA’s and local authorities. BUPA believes that the future regulation of all independent health care should be addressed simultaneously.

² Annexes not printed.

25 March 1999]

[Continued

3.7 *The Independent Hospitals Association (IHA)*

The IHA has strongly supported the PPF initiative. It has accelerated existing proposals for an independent sector complaints procedure and co-ordinated preparation by the industry for its contribution to this Inquiry. BUPA Hospitals, a member of the IHA, has participated in the IHA's submission to the Inquiry.

4. EXPANDING THE SCOPE OF REGULATION AND MONITORING

4.1 *What is currently regulated?*

Current regulation in the independent sector includes facilities used for medical, nursing, inpatient care, maternity homes, psychiatric nursing homes and premises used for surgical procedures. It does not include premises used for outpatient consultations/treatments.

BUPA's facilities are currently regulated in a number of ways, for example:

- District Health Authority inspection and registration of all BUPA's nursing homes and hospitals;
- CPA accreditation in all BUPA pathology laboratories;
- Home Office inspections of all BUPA pharmacies;
- Professional registration of all clinical staff;
- Fire inspections;
- Independent biannual Health and Safety inspections;
- ISO 9002/IIP accreditation in BUPA hospitals;
- Organisational audit;
- Measurement of health care outcomes for patients;
- Recording and measuring clinical variances;
- Care pathways for BUPA's top 50 procedures.

What is a care pathway?

A care pathway describes each stage of patient care and treatment from pre-admission to discharge and in some cases beyond. Every discipline is covered including the care and treatment received and how they would be expected to respond/recover eg surgery, physiotherapy, etc.

BUPA Hospitals is working towards care pathways for all its procedures. These are currently in place for BUPA's top 50 procedures.

4.2 *Why the review should extend current regulation*

Health care practices and technologies have developed substantially over the past 20 years.

It is BUPA's view that all health care should be evidence based and the risks and benefits subject to regulation by external monitoring, scrutiny and evaluation. This view has wide ranging implications for health care practice and would extend the scope of regulation to include:

- The entire range of independent medical practice;
- Independent care and treatment provided by dentists, opticians, dispensing pharmacists, osteopaths, midwives, nurses, physiotherapists and other professions allied to medicine;
- Complementary or alternative practitioners;
- Immunisation, screening and occupational health services.

The onus for justifying exemptions from any such regulation should lie with each profession or discipline.

The evidence base necessary to support such regulation does not presently exist. The process of researching and evaluating such practices in order to create the necessary knowledge should therefore be accelerated.

25 March 1999][Continued

5. REGULATING PREMISES AND PEOPLE

5.1 *The focus of regulation*

BUPA believes that the focus of regulation should encompass premises and people (particularly but not exclusively the health care practitioners responsible for care and treatment). Managers of hospitals and clinics should continue to take responsibility for the regulation of practitioners and other employees.

The District Health Authorities are currently responsible for ensuring the quality of care provided in regulated health care premises and the appropriateness of individuals “employed” in them. At a local level this is currently interpreted inconsistently. It would therefore be helpful to clarify the regulatory role.

5.2 *The terms of regulation*

Whilst “inputs” and “outputs” remain important terms of measure (especially at initial registration and during the development of new services), the most important test of health care is appropriate “outcomes”—the results and benefits for patients.

5.3 *Benchmark standards*

The combined work of the proposed Department of Health Research and Development Programme, the work of NICE, the proposed National Health Services Frameworks and the NHS performance management and quality frameworks, should result in benchmark standards for treatment and care of patients in the NHS and the independent sector. These should take into account differences in case mix in the NHS and the independent sector.

6. OTHER ISSUES

6.1 *Assuring the standards of independent medical practice*

It would be helpful if the General Medical Council (GMC) issued guidance that entry on the GMC specialist register should be the minimum criterion for conducting independent practice in the relevant speciality. Periodic revalidation of fitness to remain on the specialist register is also necessary.

6.2 *Co-ordinating information*

Pooling information with the NHS and other independent health care organisations about patients, practitioners, activity and outcomes would support clinical audit and the improvement of health care standards. It would also mean that “employers” could better ensure that health care professionals have the capacity and capability to meet their responsibilities.

6.3 *Complaints procedure*

There should be an external complaints procedure which embraces the NHS and the independent sector.

The IHA in principle supports a revised Ombudsman scheme that embraces both the NHS and the independent sector. Until this can be implemented, the IHA and BUPA recommend an independent procedure under the auspices of the IHA. BUPA has a complaints procedure which has clear guidelines and deadlines for the processing and management of complaints.

6.4 *The regulation of “non-acute” nursing homes*

BUPA notes that the Inquiry’s terms of reference do not exclude consideration of the regulation of “non-acute” nursing homes. BUPA is the largest provider of nursing home and residential care services in the UK and supports the proposed regulatory framework for “non-acute” nursing home and residential care services set out in the Government White Paper “Modernising Social Services”. BUPA would welcome the establishment of Regional Commissions for Care Standards but has considerable reservations about the standards proposed by the Centre for Policy on Ageing. BUPA has offered an alternative set of standards to The Royal Commission on Long Term Care.

25 March 1999]

[Continued

7. OPTIONS FOR THE REGULATION, MONITORING AND INSPECTION OF HEALTH CARE OUTSIDE THE NHS

7.1 *Removing the requirement for regulation or maintaining the status quo*

BUPA suggests that removing the Government's responsibilities for regulation of independent health care would contradict recent evidence suggesting that greater statutory regulation is required to ensure quality of health care practice. Attempts to maintain regulatory responsibilities at District Health Authority level are likely to breach the Government's own principle of good regulation and are likely to be inefficient, especially if Regional Commissions for Care Services are established.

7.2 *Other options*

We envisage three main structural options to deliver a revised regulatory framework for the independent health care sector (excluding "non-acute" nursing homes):

7.3 *Extending the terms of reference of the Regional Commissions for Care Services*

This option would integrate health and social care regulation and help to harmonise standards in both disciplines. However, it might dilute expertise and divert resources from the analysis and evaluation of health-related risks. It does not take advantage of the structure and expertise that already exists at a local level.

7.4 *Extending the terms of reference of the Commission for Health Improvement and delegating some responsibility to Regional Offices and the Royal Colleges*

This option would facilitate maximum cross-fertilisation of knowledge and common standards between the Department of Health, the NHS, and the independent health care sector and would aid standards monitoring. It would also consolidate regulatory roles and expertise at regional office level, in a manner that would complement existing and proposed responsibilities for the performance management of the NHS and the regulation of social care.

7.5 *Creating a new national statutory body, accountable to the Secretary of State for Health, responsible for regulating the independent health care sector, perhaps with delegated powers to industry representative bodies*

This option is consistent with Government policies for delegating regulatory power to industries under executive supervision. However, it fails to optimise the potential benefits of closer collaboration between the independent sector and the Department of Health and NHS at policy and higher management levels.

7.6 *BUPA's preferred option*

BUPA's preferred structural option for the regulation of the independent health care sector would be to extend the terms of reference of the Commission for Health Improvement and delegate some responsibility to regional offices and the Royal Colleges. This option would:

- Offer the greatest flexibility
- Introduce common standards across the NHS and the independent sector
- Maximise information sharing
- Introduce more effective monitoring
- Consolidate and complement existing arrangements
- Offer the best protection for patients
- Provide a level playing field for the NHS and the independent sector
- Encourage regulatory equality
- Take advantage of the expertise and structure which already exists

Any regulation should be in the interests of patients, staff and public, practical to implement, cost effective, flexible and not restrict the freedom to trade.

We are happy to provide additional evidence to support any of the issues raised in this document.

25 March 1999]

[Continued]

BIBLIOGRAPHY

BETTER REGULATION TASK FORCE, principles of Good Regulation and The Better Regulation Guide and Review of Long-Term Care, Cabinet Office, London 1998.

BUPA, Response to "A First Class Service", Consultation Document on Quality in the New NHS, London, September 1998.

BUPA HOSPITALS, Clinical Services Strategy, London, 1998.

DEPARTMENT OF HEALTH, Modernising Social Services, Stationery Office, London, November 1998, Cm 4169, ISBN 0 10 141692.

JONES R, Registered Homes Act Manual, 2nd edition, Sweet and Maxwell, London, 1993, ISBN 0 421 480020 3.

NHS CONFEDERATION, A template for open reporting on independent acute hospitals and services, London and Birmingham, September 1998.

NHS EXECUTIVE, A First Class Service, Consultation Document on Quality in the New NHS, London and Leeds, issued under Health Service Circular (HSC) 1998/113.

NHS EXECUTIVE, Risk Management in the NHS.

SINCLAIR J, Collins Cobuild English Language Dictionary, Collins, London 1987, ISBN 0 00 370023 2.

Memorandum by General Healthcare Group

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 51)

INDEX

Item

1. Executive Summary
2. Introduction and Scope of Response
3. Background to the Areas of Independent Healthcare where General Healthcare Group has a presence
4. Overview of the Current Regulatory Regime
5. Observations on Adequacy and Extent of Present Regime
6. Possible Improvements to the Existing Regime
7. A Better Alternative
8. Implementation and Costings
9. Complaints
10. Conclusion

1. EXECUTIVE SUMMARY

General Healthcare Group is one of the largest independent sector providers of healthcare in the UK. It has activities across over 40 acute surgical and medical hospitals which trade as BMI Healthcare, and 11 acute psychiatric specialist care hospitals which trade as Partnerships in Care. These activities amount to some 180,000 inpatient treatments annually, some 750,000 outpatient visits and some 230,000 psychiatric patient days annually. General Healthcare Group welcomes this review of the adequacy and extent of the regulation of private healthcare and the attendant complaints mechanisms.

General Healthcare Group:

- (1) Notes that the existing regulatory framework is based on circumstances prevailing in the independent sector some time ago and that it has become inappropriate to the independent healthcare of today—particularly in relation to the provision of acute surgical and medical services (paras 5.2–5.5).
- (2) Recommends that the existing regulatory framework be replaced by inclusion of the independent sector within the scope of the proposed National Institute for Clinical Excellence and of the work of the proposed Commission for Health Improvement in clinical and hospital standards nationally (para 7.5). The independent sector must have representation on the Commission and remain free from the prescription of central resource planning for the NHS (if such activity would fall within the

*25 March 1999]**[Continued]*

remits of either the Commission or the Institute) (para 7.11). If inclusion of the independent sector is not achievable, the existing regulatory framework should be updated to reflect present conditions (para 6.1).

- (3) Recommends that, in the best interests of patients, and as part of such reform, a new nationally based system of accreditation of healthcare service proprietors, healthcare premises, and healthcare professionals be introduced (para 7.7). Better national training and accreditation of inspecting officers to ensure the consistent application of nationally defined standards is also required, (paras 6.1.4, 7.11).
- (4) Recommends that there should be core clinical and service standards to which all providers of independent healthcare must adhere (para 6.1.6, 7.11). This is a critical element in assuring patient safety.
- (5) Recommends that the on-site manager of the service proprietor should become the principle on-site licencing focus, rather than the senior nurse in each unit (para 6.1.6, para 7.11). This would be similar to the position prevailing in the NHS. In some cases this individual might in fact be a nurse, but accountability would be as a result of his or her management responsibility.
- (6) Recommends that complaints procedures across the whole of the independent sector be at least as effective as the present or any future system in the NHS. A key requirement would be for conformance of all providers to the provision of independent external adjudication.
- (7) Suggests that there may be a useful template for creation of a regulatory scheme applicable equally to both the independent sector and the NHS—the recent experience of establishing the Human Fertilisation and Embryology Authority.

The Committee is cordially invited to visit any one or more of the acute care or psychiatric hospitals of General Healthcare Group, should it regard this as helpful in obtaining a picture of service provision.

2. INTRODUCTION AND SCOPE OF RESPONSE

2.1 General Healthcare Group is concerned to ensure the delivery of the highest possible standards of patient care and overall quality of service to users. As the largest independent provider of both acute surgical and mental health services, it has been at the forefront of the drive to improve clinical and service standards across the independent sector. General Healthcare Group therefore welcomes the Committee's review of the registration regime applicable to the provision of healthcare outside the NHS. General Healthcare Group has for some time been concerned at the under-regulation of parts of the independent sector and sees the present review as an opportunity not only to safeguard patient safety across the sector as a whole, but also to redress unfair competitive advantage and to ensure favourable public perception of all sectors of independently provided care.

2.2 With 52 hospitals registered with Health Authorities across the United Kingdom, General Healthcare Group also believes that it has a useful contribution to make to the debate on the present system of registration and possible future change.

2.3 In responding to the invitation for submissions, General Healthcare Group has confined itself to four essential issues:

- (1) An overview of the present system, and our present concerns with the adequacy and extent of that system;
- (2) Suggestions for improvements to the present system (although this is not the preference of General Healthcare Group for the future);
- (3) Describing what General Healthcare Group regards as the best available option for a new system of regulation of independent healthcare; and
- (4) A summary of complaints handling within General Healthcare Group.

2.4 This Memorandum has been prepared to provide a summarised view on the above. If further detail is required General Healthcare Group will be happy to expand on its thinking by meeting with representatives of the Committee.

2.5 General Healthcare Group has also appended copies of its own Complaints Procedures for the information of the Committee.³ There are two, one for private patients within the surgical and medical hospitals, the other for patients (the majority of whom are detained under the Mental Health Act and all of whom are longer stay patients) within the psychiatric hospitals.

³Appendices not printed.

25 March 1999]

[Continued]

3. BACKGROUND TO THE AREAS OF INDEPENDENT HEALTHCARE WHERE GENERAL HEALTHCARE GROUP HAS A PRESENCE

3.1 General Healthcare Group operates in three areas of clinical service:

- (1) Acute surgical and medical hospitals;
- (2) Acute psychiatric specialist care;
- (3) Occupational health and health screening (not necessarily on hospital sites).

3.2 The first two activities operate in a regulated regime and aspects of that are developed in the remainder of this Memorandum. The last activity, whilst not presently subject to regulation, is one where General Healthcare Group would welcome the creation of a regulatory regime to achieve common high quality standards of service delivery, although the general nature of the level of clinical intervention which is undertaken here is such that there should be less concern.

Acute surgical and medical hospitals—Scope of sector

3.3 Over 11 per cent of the UK population chooses to subscribe to insurance products enabling them to be treated privately should they so wish. We estimate that a further 2 per cent of the population chooses to pay for such treatment from their own resources. The acute surgical and medical sector meets that patient demand. The sector comprises some 11,000 beds, across some 230 units with 1997 revenues of some £1.25 billion.

3.4 The sector undertakes a significant proportion of the nation's elective surgery, relieving waiting list pressure on the NHS. This elective surgery includes many complex and resource consuming operations such as cardiac surgery and hip operations. Overall it is estimated⁴ that 20 per cent of elective surgery in the UK is undertaken within the private sector.

3.5 General Healthcare Group does not propose to summarise the workings of the sector in any detail, other than to refer the Committee to Chapter 3 of the Report, *"Private Medical Services"*, published⁵ in 1994. Whilst some of the ownership details within the sector have changed, the description of the functioning of the sector is still both accurate and comprehensive. Important background information is also to be found in the Independent Healthcare Association's submission, in the preparation of which General Healthcare Group assisted.

BMI Healthcare—Position in sector

3.6 General Healthcare Group provides its acute surgical services under the BMI Healthcare (BMI) brand, and has over 40 hospitals with a total of 2,300 beds, 115 operating theatres, 39 intensive care beds (plus over 100 high dependency beds), total annual revenues of some £300 million and employing over 4,000 people. Hospitals range in size from a 9 bed unit operated jointly with an NHS Trust in the Midlands to a 177 bed district general hospital with six theatres and a seven bed intensive care unit in Manchester. In the larger hospitals, intensive care units are fully operational to support the neurosurgical, cardiac, orthopaedic, vascular and other complex surgery undertaken.

3.7 Amongst the 42 hospitals are eight joint ventures with NHS acute trusts, where BMI manages the private facilities and the benefits are shared with the host NHS hospital. In 1998 BMI contributed some 7 million to the NHS in these units alone. This comprised a mix of purchased services, rent payments, and share of surplus generated from private patients.

3.8 BMI has led the way in the independent surgical sector in the use of Consultant credentialling, total quality management and accreditation systems. It was the first organisation to introduce, with the active participation and support of its National Medical Advisory Committee, a procedure requiring all admitting Consultants to demonstrate their capability in the use of minimally invasive surgery. Where a new procedure is developed it is BMI's policy to require local Medical Advisory Committees to ensure the competence of practitioners in that procedure, as part of our commitment to total quality service delivery. Review of admitting Consultants is also a key component of the internal accreditation process. A copy of BMI's policy is attached as Appendix 4.

3.9 Quality is a critically important part of BMI's activities. The majority of BMI's hospitals have achieved external accreditation (either Health Quality System or, International Service Organisation standard 9002, [the quality management standard]). Those that have not yet done so are well advanced in the process. Quality is supported by significant investment in training and many hospitals have now achieved accreditation with Investors in People.

⁴Independent Healthcare Association, estimate.

⁵Report of the Monopolies and Mergers Commission, dated February 1994. HMSO, Cm 2452.

25 March 1999]

[Continued

Independent Acute Psychiatric Care—Scope of sector

3.10 Independent sector psychiatry comprises some 15,610 beds, across 84 units with estimated⁶ annual revenues of some £225 million and employing over 15,500 staff. The scope of the sector ranges from general psychiatry (neurotic illnesses, eating disorders, substance abuse) to secure forensic services for patients with enduring mental illness, personality disorder and learning disability.

Partnerships in Care—Position in sector

3.11 Partnerships in Care (PiC) is a wholly owned subsidiary of General Healthcare Group, and the name under which the Group provides its psychiatric services. It has some 650 beds and in 1998 provided some 230,000 patient days of care to the NHS, mainly through extra contractual referrals (ECRs). PiC provides an important service to NHS and Social Services purchasers, enabling them to place patients in high quality, ethically operated units with a commitment to patient welfare and treatment.

3.12 PiC's core competencies are in the areas of acute mental illness, personality disorders, learning disabilities, acquired brain injury and employee counselling services. PiC operates at the more acute and secure end of the service spectrum, and provides a home to a large number of patients detained under the Mental Health Act, 1983—in fact over 50 per cent⁷ of all detained patients outside the NHS are with PiC.

3.13 It is important to emphasise that, aside from registration under the Act, PiC's hospitals are subject to the same statutory inspection regime as comparable NHS units. This involves the Mental Health Act Commission (MHAC) in regular inspecting visits and meetings with staff and patients. Major purchasers of services are also invited to meet with MHAC Commissioners privately during visits and to attend feedback meetings. They also receive copies of MHAC reports and the PiC response, including actions.

3.14 All PiC mental health facilities work within the framework of the care programme approach. This requires the continued involvement of health purchasers through regular review meetings in monitoring the progress of their patient whilst in our care. This therefore acts as a monitoring mechanism on an individual patient basis. The implementation of the care programme approach within PiC is currently being independently evaluated by King's College, Centre for Mental Health Services Development through a three year research project.

3.15 PiC is committed to quality improvement through working to the standards developed in 1997 by the Health Quality Service (formerly King's Fund Organisational Audit). All facilities have either been accredited or are currently awaiting results of accreditation following recent surveys. All facilities are accredited with "Investors in People" (with the exception of one recently opened unit). PiC is also committed to training with 3.5 per cent of its budget allocated to this important area. It offers its staff participation in a range of internal and external training resulting in NVQ's through to post-graduate degrees (this includes post-graduate ENB courses to both PiC and NHS staff). PiC regularly accepts students on placements during their clinical training in nursing, psychology, occupational therapy and social work. PiC's commitment to research is demonstrated through joint appointments in psychiatry and psychology with Cambridge University. These appointments are of clinicians who work across both PiC and the Institute of Criminology.

4. OVERVIEW OF THE CURRENT REGULATORY REGIME

Background to current regime

4.1 The core of the existing regulatory regime comprises the Registered Homes Act, 1984 (the Act); the Nursing Homes and Mental Nursing Homes Regulation 1984 (Regulation); and guidance issued from time to time by the Department of Health and the National Association of Health Authorities (NAHAT) subsequently the NHS Confederation (Guidance). Individual regulatory authorities also have their own written policies to regulate the registration of the independent sector within their jurisdiction, (Policies). The background to the change in the regulatory framework is set out in Appendix 5.

Scope of Current Regime

4.2 In addition to compliance with the Act, Regulation Guidance and Policies, the independent sector is subject to control by a number of other statutory bodies amongst which are:

- Health and Safety legislation
- Environmental Health Officer
- Pharmaceutical Society registration

⁶ Source: Fitzhugh Directory 1998

⁷ Source: Department of Health Statistical Bulletin, November 1998.

25 March 1999]

[Continued]

- Radiological Protection (Ionising Regulations) control regime
- Medicines Control Agency
- Human Fertilisation regulation
- Planning regime of the local authority
- Waste management issues—Environmental Agency
- Fire Authority regime
- Pressure vessels and lift and hoist inspection regime

4.3 In psychiatric units, additional controls exist as a result of

- Mental Health Act
- Mental Health Act Commission
- Referring health authority scrutiny, as purchaser
- Social Services Inspectorate

5. OBSERVATIONS ON ADEQUACY AND EXTENT OF PRESENT REGIME

(a) Adequacy

5.1 General Healthcare Group has long and extensive experience across both its surgical and psychiatric activities of dealing with NHS and social service funded patients, in addition to insurance and self-pay funded patients in its surgical and medical workload. As a result General Healthcare Group has had direct experience of regulation and service levels required across both the public and the private sectors. General Healthcare Group therefore believes it is well placed to comment, given both the breadth and the depth of its own experience.

5.2 The existing regime is based on earlier legislation, enacted when there was little, if any, significant complex acute surgery undertaken in private acute care hospitals. Most surgical work was undertaken in what were, for practical purposes, nursing homes with operating theatres added to them. This, typically, was what registering authorities were required to regulate.

5.3 As a result there was, and now remains, a nursing home focus in the legislation. As the sector has developed, so the range of services has developed to a point where the independent sector undertakes very significant proportions of the national service provision. Whilst it has been attempted to develop Guidance to reflect changing circumstances, legislation has not kept pace with the change in the very nature and complexity of the subjects of regulation.

5.4 The Act, the Regulations (and to a lesser extent the Guidance) still proceed with independent hospitals (whether acute care or psychiatric) as almost an afterthought in the regulatory regime. As a result, each Health Authority inspectorate attempts to apply general statements relating to the adequacy of particular service elements. In so doing they are forced to extend the meaning of the written standards. This in turn creates significant variation in the standards applied locally. As a result the sector has to deal with a number of different and differently applied sets of standards rather than a single, nationally applied, uniform standard. Local interpretation of the Act varies widely—there is no single national standard over either what the important issues are, or over what the appropriate standard actually is. The touchstone is simply individual judgement on what amounts to “sufficient and suitable” under the legislation.

5.5 As a general proposition the approach taken in the existing regulatory regime is to focus on the inputs to the regulated service, rather than on the outputs. Good practice in healthcare over the recent past has however evolved to a point where outputs are seen as the important parameter.

5.6 Whilst good local working relationships are important, a relationship based accreditation situation is inimical to the application of national standards, or the acceptance by registration officers in one locality of an established standard, or even of the “*person registered*”⁸, in another part of the country.

5.7 The “*person in charge*” for the purposes of the Act and the regulations is required⁹ to be an individual who is either a medical practitioner or a qualified nurse. However, with developments over the last 20 years, multi-disciplinary activities have increasingly been undertaken within independent hospitals—which may now be outside the direct management control of the senior nurse.

⁸ Under section 23 of the Registered Homes Act 1984.

⁹ Section 25(3)(f), Registered Homes Act 1984.

25 March 1999]

[Continued

5.8 A further consequence of change in the provision of private patient services is the creation of an anomalous situation for NHS private patient units. Even where such units are physically separate from their host hospital, they are not subject to the existing regulatory regime applicable to healthcare outside the NHS. They may be part of NHS internal service management or clinical control procedures, but this varies from Trust to Trust and they remain, therefore, in essence under-regulated.

5.9 At a more detailed level, comments from our own units indicate the following suggestions from an operational level:

- A number of Health Authorities approach registration from the perspective of adequacy rather than the quality level of the service provided. Often the focus is on welfare of residents (adequacy of cutlery, crockery, etc) and less on clinical safety of patients. This type of approach may miss real issues, such as clinical outcomes or infection rates.
- Some inspecting officers may have limited experience or knowledge of the key clinical and technical areas (such as theatres, wards, ITU, laboratories and imaging departments) which they are inspecting. As a result the level of analysis and scrutiny may be reflective of that experience.
- The regulatory regime does not take account of successful participation in accreditation schemes, such as ISO9000, Health Quality Service (formerly King's Fund Organisational Audit). Interest in accreditation only increases where a local NHS unit is itself trying to get accreditation. In those cases a keener interest is seen in policies and procedures underpinning accreditation, and a realisation develops that best practice must be "shared". A substantial investment is thus transferred to a potential competitor.
- There is no informal disputes resolution process to deal with any disagreements over interpretation of the Regulations, only a formal right to make representations to the regulatory authority as part of the process of cancellation of registration and a confrontational appeal to a Tribunal.
- There is little acceptance in the Regulations of technological change—for example in many units information required to be maintained in the patient register¹⁰ is also held on a secure computer system. Whilst inspecting authorities may be willing to accept this as a proper record, they believe that they are constrained by the Regulations from doing so.

(b) *Extent*

5.10 The difficulty over the extent of the present regime is that the definitions used to determine whether a service or unit falls within its scope are limited. Certain activities and premises that should be regulated (such as clinics, minor surgery units, and some other treatment centres) fall well outside that scope. In part this reflects the fact that since the definition was created, medical technology has moved on. Quite extensive (and in an unregulated environment, potentially dangerous) procedures may be undertaken in premises falling outside the scope of the Act. This would include surgery in consulting room suites, or in properties where the primary purpose was the undertaking of consultations.

5.11 A number of cosmetic surgery and alternative services are conducted on this basis and these have a damaging effect on the credibility of the independent sector as a whole. As unregulated entities they are also able to skimp on supporting clinical and diagnostic resources and thereby function on a lower cost base. This enables them to draw in patients activity who are price sensitive rather than safety conscious, or who wrongly assume that the activity in question is appropriately regulated.

5.12 The use of "premises" as the core element in registration (albeit that Part II of the Act then refers to activities undertaken) is in our view now the wrong approach. To ensure the safety of patients we believe that the provision of services should be the key registration parameter, premises being one additional element. In our view, the present premises orientated regime misses much of importance.

6. POSSIBLE IMPROVEMENTS TO THE EXISTING REGIME

6.1 If updating the existing regime were deemed sufficient (a position which General Healthcare Group does not recommend) the improvements that General Healthcare Group would wish to see implemented are:

- (1) The introduction of a new category of registrable entity under the Act, that of Independent Healthcare Facility. This would probably need to include any unit or premises where any clinical intervention, including assessment or diagnosis, were undertaken. This would then enable separate service standards to be developed for such units, rather than as at present trying to extend standards applicable to nursing homes and their long-stay residents. This is similar to the introduction in 1984 of a new statutory entity, the residential home, under the Act.

¹⁰ Reg. 7(1) and Schedule 4, 1984 No. 1578.

25 March 1999]

[Continued]

- (2) Introduction of baseline core clinical and service standards that every independent unit should adhere to. These should be laid down as minimum registration standards for hospitals. They should include the provision of 24 hour, on-site, resident medical officer cover; appropriate control of infection policies; successful participation in relevant accreditation and monitoring processes; provision of the relevant equipment, facilities and skilled staff for the procedures to be undertaken; and adherence to an externally supervised complaints policy.
- (3) Establishment of additional service standards by reference to the levels of complexity or acuity of the clinical service actually undertaken. In this way those units undertaking neurosurgery or cardiac surgery would be required to achieve a service level appropriate to them, rather than that appropriate to units undertaking less complex procedures.
- (4) Better national training and accreditation of inspecting officers to ensure the consistent national application of nationally defined standards.
- (5) Clear statement from the Department of Health that certain levels of independent accreditation achieved by independent hospitals are to be acceptable to inspecting officers as indicators of the baseline service quality of those units.
- (6) Redefinition of the "Person in Charge" under the Act to ensure that the responsible senior on-site Hospital Manager or Director (rather than necessarily the senior nurse) took on the primary registration responsibility. There might also appropriately be a register of individuals who had been adjudged not fit and proper persons to exercise such a function.

7. A BETTER ALTERNATIVE

7.1 General Healthcare Group believes that, against a background of change in the approach to clinical quality within the NHS, the time is ripe to consider generating parallel developments in the regulatory regime applicable to the provision of healthcare outside the NHS.

7.2 In approaching this question the key considerations must be the safety of patients, the achievement of the best possible clinical outcomes, and the assurance of high quality service provision to all users. In turn, this will require a new registration focus on clinical and service outcomes; transparency of information, and rapid intervention should service quality deteriorate. Of course, the adequacy of the premises will remain an important factor.

7.3 A critical issue will be to ensure that the remaining unregulated services or premises are brought into the regulatory regime. Appropriate regulation—particularly where it draws on nationally established best practice, (whether NHS or otherwise)—will enable sensible comparisons to be drawn between different clinical settings, and transparent judgements to be made about best value for purchasers and consumers. Open reporting is seen as a key component of this. In our case significant interchange with the NHS and Social Services has to some extent enabled us to move down the path of external inspection and scrutiny by purchasers.

7.4 The recent White Paper, *A First Class Service*, at its paragraph 4.37 in the context of the development of the Commission for Health Improvement (CHI) stated:

"We are currently looking at options for future regulation of the independent acute sector. The Commission's role in this area may need to be assessed more fully in that light."

7.5 The White Paper went on to indicate that, in any event, the Commission might well have a role in monitoring the service levels of the independent sector where the particular entity provided a significant proportion of services to the NHS. General Healthcare Group believes that inclusion of the independent sector—as a whole—within the scope of the Commission is important as part of a national drive to raise service standards across healthcare as a whole to a new, uniform, high level. General Healthcare Group also believes that the all-embracing approach shown in the White Paper, and in the other initiatives of the Department of Health and the various medical Royal Colleges, create a unique combination of circumstances in which the implementation of change become achievable.

7.6 General Healthcare Group has considered how, were it in the Committee's place, it might wish to approach its task. General Healthcare Group suggests that a sensible approach is to ask what system of regulation would be most appropriate if there was no existing regime.

7.7 Based on this approach, GHG believes that the interests of patients, and their safety, would be best served by the introduction of a nationally based system for the accreditation and regulation of:

- healthcare service proprietors,
- healthcare premises, and
- healthcare professionals.

*25 March 1999]**[Continued]*

7.8 This three pronged approach could be applied to all healthcare provided outside the NHS and in a manner which ensures the application of uniform high standards consistent with—and directly comparable to—those within the NHS. This approach would allow for the development of a nationally applicable, cross sectoral set of minimum clinical standards, to which healthcare should be provided—irrespective of sector. General Healthcare Group sees this approach as consistent with the aspirations of the White Paper and one which would ensure the provision of high quality services to patients wherever they were treated.

7.9 The concept underlying the three pronged approach is to ensure that healthcare as a whole is regulated, and that within such regulation there is scope to define service and quality requirements at levels appropriate to the scale and complexity of the service actually provided. Additionally, by focusing on the three elements of:

- service proprietors (such as ourselves, BUPA, or Nuffield);
- premises (such as hospitals, free standing cosmetic or hernia clinics, and consulting rooms where intervention may take place) and
- professionals (such as doctors, dentists, osteopaths and other practitioners), the scope for there to be unregulated areas where bad or unethical practice can continue to flourish is reduced.

7.10 In this way one concern at the use of the independent sector for NHS waiting list initiatives—the variable quality levels found within the private sector—could be removed. Certainly this approach is consistent with the all-embracing national approach proposed for NICE and CHI in the White Paper “A First Class Service”.

7.11 In relation to the more detailed functioning of an alternative regulatory regime, the points put forward in section 6 above, as improvements to the existing regime, apply equally. The independent sector must however have representation on the Commission and remain free from the prescription of central resource planning for the NHS (if such activity would fall within the remits of either the Commission or the Institute).

8. IMPLEMENTATION AND COSTINGS

8.1 General Healthcare Group notes¹¹ that the Commission is to be funded from existing resources. In a similar way the fees already paid by independent hospitals to registering Health Authorities could be redirected to the Commission and may well cover most, if not all, of the incremental cost of including the sector within its scope.

8.2 So far as implementation, General Healthcare Group believes that the recent experience of the Department of Health in establishing the Human Fertilisation and Embryology Authority, and of the attendant legislation and regulation, will be a useful basis for consideration of a regulatory scheme applicable equally to both the independent sector and the NHS.

9. COMPLAINTS

9.1 The way in which any organisation communicates with and responds to its customers is fundamental to its culture, style and attitudes. Best practice in this, including the handling of complaints, is particularly important in the whole of the healthcare sector because of the nature and personal impact of the service provided to patients. In essence, comments and complaints should be part of a virtuous circle of continuous improvement. Sadly, this best practice is not ubiquitous.

9.2 General Healthcare Group has, as a matter of long-established policy, a commitment to set and to deliver the highest relevant quality standards in everything we do. Our promise to our patients is to listen carefully, to investigate and to learn from any comment or complaint that they raise with us. We strive to always investigate thoroughly and impartially and to resolve any dispute with honesty, fairness and sensitivity.

9.3 Within the acute surgical and medical hospitals complaints are relatively rare, but where they occur it is critical that they are dealt with expeditiously and in a way which gives the complainant confidence that they are being taken seriously and dealt with fairly and honestly. Most complaints can be resolved locally, but more serious complaints generally require involvement from the centre.

9.4 Investigation in a General Healthcare Group hospital will always include relevant procedural checks to assure conformity with our quality standards and with the potential to identify improvements for the future clearly in mind. Review of clinical matters may involve members of our medical advisory committee (one is established at each of our hospitals with members drawn from the senior consultants with admitting rights at that hospital).

¹¹ White Paper, *A First Class Service*, page 51.

*25 March 1999]**[Continued]*

9.5 Where a complaint cannot be resolved locally to the satisfaction of the complainant, for any reason, the case is escalated to the relevant Managing Director at head office.

9.6 In response to constructive criticism from patients, we have added a further referral and adjudication step to this process—that of independent external review. Whilst this has not yet been used by a complainant, (in part reflecting the low level of complaints actually received), preliminary indications are that this will be regarded by complainants as a positive enhancement to the scope of the policy. A copy of this policy is attached as Appendix 1. The use of this new, end-stage, procedure has two significant benefits to the individual patient and to broader patient interests:

- (1) the reassurance that, in the event of dissatisfaction with our response to a complaint, an external and independent review will take place to check on our assessment of the case
- (2) that, in the event of a patient being dissatisfied with our response to a complaint, the patient has an alternative to recourse to law (although our external and independent review process in no way restricts the patient's right to seek legal redress at any time).

9.7 Within the acute psychiatric specialist care hospitals, patients are encouraged to bring any concerns forward under the aegis of the complaints policy. The policy, which is based on current NHS guidance, complemented by our independent advocacy services, helps ensure openness of information and that there is a clear and unambiguous process for resolving issues. The complaints policy and its implementation is regularly reviewed by the Mental Health Act Commission from a patients perspective in addition to regular reviews by registering authorities and purchasing authorities. A copy of the policy is attached as Appendix 2.

9.8 In our view external, independent review processes which provide timely adjudication in disputes between patients and their healthcare providers are an essential part of delivering total quality in the sector. Complaints procedures across the whole of the independent sector should be at least as effective as the present or any future system in the NHS. A key requirement would be for conformance of all providers to the provision of independent external adjudication.

10. CONCLUSION

The current system of regulation of healthcare outside the NHS is inappropriate to the breadth and depth of services now provided by the independent sector. To adjust the existing regime would be to complicate an already muddled patchwork and retain its inherent flaws.

We firmly believe that in the interests of transparency and informed decision-making, regulatory and performance standards should be set and managed on a common basis across the whole of healthcare—both publicly and privately funded.

Common core standards for clinical and service aspects of healthcare, inspection, monitoring, reporting and complaint regimes will provide all stakeholders with a proper basis for judging performance.

All patients have the right to expect, as a given, a safe and secure environment with clinical standards uniformly and universally applied.

The vision of NICE and CHI should embrace the healthcare of the nation as a whole. We enthusiastically support that vision.

January 1999

Memorandum by Nuffield Hospitals

PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 36)

1. EXECUTIVE SUMMARY

The existing high quality of healthcare provided in hospitals in the United Kingdom could be further enhanced by Government action in respect of the following aspects:

- (a) An improved system for licensing all types of healthcare provision. We recommend that legislation be introduced to create an independent regulatory and inspecting body for all healthcare in the United Kingdom, including the National Health Service. (see paragraph 5)
- (b) The provision of a mandatory system to monitor the quality of services provided by specialist doctors. (see paragraph 6)
- (c) A method of determining the optimum treatment protocol for particular conditions. We recommend that a national body be established for this purpose. (see paragraph 7)
- (d) The further development of patient complaint resolution procedures. We recommend that all providers of healthcare be required to participate in a system which provides at the ultimate level, an element of independent arbitration. (see paragraph 8)

25 March 1999]

[Continued]

MEMORANDUM

2. (a) This memorandum has been produced in response to the invitation contained in Health Committee Press Notice No 1 of Session 1998–99 dated 7 December 1998.
- (b) The memorandum addresses issues which relate primarily to acute medical and surgical hospitals and, except by coincidence, does not comment upon matters affecting any of the other major areas of healthcare provision such as psychiatric and substance abuse hospitals, primary care or long term care.

NUFFIELD HOSPITALS

3. (a) “Nuffield Hospitals” is the trading name of Nuffield Nursing Homes Trust which was established in 1957 “to prevent, relieve and cure sickness and ill health of every kind.....” It is a company limited by guarantee with charitable status. As a consequence of this status it has no shareholders and distributes no dividends. The financial surplus generated each year is reinvested in the operation of the Trust, primarily in the provision of new and replacement equipment, facilities and services. There are up to 200 members of the company who elect a Board of Governors to arrange and supervise the affairs of the Trust.
- (b) (i) Nuffield Hospitals operates 39 hospitals and one care of the elderly centre, primarily throughout England and with one hospital in Glasgow.
- (ii) The hospitals provide healthcare to over 750,000 patients each year ranging from outpatient consultation with a specialist doctor, to complex major surgery supported by departments of radiology and diagnostic imaging, pathology, pharmacy and physiotherapy and rehabilitation.
- (iii) The total number of staff employed (including full and part-time) is approximately 5,750. The Trust runs its own training and development functions including a School of Nursing which is recognised for a number of English National Board approved courses and which takes students for training from all sectors including the NHS and the armed forces medical services.
- (iv) Nuffield Hospitals has a 13 per cent market share of the private acute medical and surgical sector and is the third largest provider in terms of bed numbers and financial turnover after General Healthcare and BUPA.
- (v) The development of the group commenced in 1957 with one hospital and then largely depended upon local community initiatives including significant local fund raising. The hospitals today remain focused upon their local community each serving a geographically limited catchment area. The Trust has no endowment fund and exists by charging fees for its services to patients, medical insurers and other purchasers of healthcare such as employers.
- (vi) The Trust has been developing the size and number of its hospitals in recent years both by constructing new facilities, expanding existing sites and acquiring hospitals owned by others and investing substantial funds in them to upgrade their equipment and services. In 1997 expenditure on capital developments and acquisitions totalled some £46 million.
- (vii) The current Corporate Objective of the organisation is stated as follows: “To provide, throughout the United Kingdom, financially viable private facilities and services for the diagnosis and treatment of acute ill-health and the promotion and maintenance of good health. This provision will be of a standard and quality which is perceived by its users to match their expectations for excellence of service, which is seen to offer good value for money and which meets in full the criteria laid down from time to time by relevant regulatory bodies.”
- (viii) Extensive measures are taken to ensure that the healthcare services provided by the Trust meet the needs and expectations of patients and users. Provisions include external audit and accreditation schemes such as the King’s Fund Accreditation Audit plus extensive on-going patient satisfaction surveys, which indicate overall satisfaction levels consistently well in excess of 90 per cent and a complaints procedure which provides for referral of unresolved complaints from hospital level, direct from the patient to the Group Chief Executive. In 1998 out of over 750,000 patient episodes of care 59 (57 in 1997) complaints of all types were received by the Group Chief Executive.
4. (a) The increase in the range and complexity of high quality modern medicine and the increase of patient expectations has meant that systems, procedures and attitudes which were valid some years ago must now be questioned as to their adequacy. Individual providers of healthcare can, and often do, make extensive voluntary arrangements to accommodate these changing needs by the creation of ad hoc solutions, sometimes on a co-operative basis with other providers. However, the voluntary nature of such arrangements and the limited number of participants can result in a less than

*25 March 1999]**[Continued]*

universal application. The difficulties caused by those who do not participate in such voluntary arrangements can often impact upon all providers of healthcare, especially in terms of public confidence and understanding.

- (b) We believe that there are four particular areas where real improvements can be made in a relatively short timescale to standards of patient care and hence to customer confidence in the whole healthcare system. We therefore recommend that Government should accord priority to them. It is acknowledged that action is being taken or considered in all of them at this time.

They are:

- The system for Licensing of all types of healthcare provision.
- The provision of a mandatory system to monitor the quality of services provided by specialist doctors.
- A method of establishing the optimum treatment protocol for particular conditions.
- The further development of patient complaint resolution procedures to encompass all elements of healthcare provision and to provide at the ultimate level an element of independent arbitration.

THE LICENSING SYSTEM

5. (a) The principal regulation of private acute medical/surgical hospitals is by the Registered Homes Act (1984). All other relevant legislation, such as Health & Safety at Work, environmental health, employment, planning, Companies Acts etc also applies to them as to any other private sector body.

(b) The Registered Homes Act is not comprehensive in that it does not apply to all providers and in particular it does not apply to private patient facilities operated within National Health Service Hospitals.

(c) Many non hospital based providers of healthcare are not covered by the Registered Homes Act and in effect are unregulated because they are not independently licensed to provide care to patients eg free standing providers of primary care and health screening, independent contractors such as physiotherapists and chiropractors, out patient consulting and treatment centres and diagnostic centres providing pathology and medical imaging such as Xray, MRI and CT scanning.

(d) The existing limited provisions of the Registered Homes Act are administered by the National Health Service, normally by the local Health Authorities. Although efforts have been made in recent years to improve matters, we believe that the process of inspection, reporting and licencing (registration) is inconsistent and sometimes lacking in clarity and quality.

(e) The licencing legislation does not apply to NHS hospitals which undergo no inspections of this type and have no external regulation of minimum standards. This is particularly significant in respect of the large amount of private patient activity in many NHS hospitals today but, of course, also supplies to the general services provided by them.

(f) We note that Government intends to introduce independent inspection for nursing homes, which are regulated on the same basis as private hospitals under the Registered Homes Act.

(g) Recommendation.

It is recommended that legislation be introduced to create an independent regulatory and inspecting body for all healthcare in the United Kingdom, including the NHS, which will establish minimum standards of quality and safety for patients, staff and public, including the minimum levels of provision of staff, equipment and facilities for the various types of services provided. Naturally, such a system requires detailed working through: we believe, however, that the principle of universal regulation is essential.

MEDICAL QUALITY ASSURANCE

6. (a) The provision of high quality healthcare to patients depends upon the combination of many skills and contributions. The contribution made by specialist doctors is a large and fundamental part of that process. The increasing complexity of modern medicine and the pace of change make the maintenance of standards of service by specialist doctors a complex issue. Although many interested parties are actively considering the situation and either have, or are planning the implementation of various programmes, there is still no mandatory and comprehensive system which monitors and reports the quality of work of each specialist doctor. We acknowledge that it may be difficult to isolate the contribution of a doctor when so many variables can affect the outcome of treatment, but public opinion seems to expect individual performance measurement and we believe that it should be achievable.

*25 March 1999]**[Continued]*

(b) A number of healthcare providers, such as Nuffield Hospitals, have begun to put in place extensive programmes to monitor the delivery of clinical treatment against predetermined protocols. However, these programmes are limited to the patients treated in a particular hospital and consequently do not provide a comprehensive picture of the performance of a doctor who may well work in a number of hospitals.

(c) At the present time recognition as a specialist doctor is by inclusion on the appropriate register of the General Medical Council. We believe that in future this should be for a predetermined, limited period of time and that re-registration should be required after a specified period. The criteria for achieving re-registration or revalidation of the licence to perform as a specialist doctor in a particular clinical specialty or sub-specialty should include a review of the actual clinical performance of the individual in that field as opposed to some demonstration of theoretical knowledge.

(d) Recommendations

- (i) A mandatory unified system to monitor and report the quality of clinical work of specialist doctors across all sectors should be established.
- (ii) Maintenance of specialist status should be subject to periodic review based upon the quality of work previously achieved.

OPTIMUM TREATMENT

7. (a) At the present time there appear to be real variations in clinical practice between different specialist doctors. There is no authoritative source of expert opinion which identifies the optimum method of treating a particular patient and condition and which publishes the norm against which individual patient requirements can be considered.

- (b) The Government intends to establish a National Institute for Clinical Excellence, but we note that this is in the context of setting quality standards for the NHS alone, not for the whole healthcare sector.
- (c) The performance of specialist doctors and hospitals against the recommended norms of treatment should be monitored across all their clinical activity in a consistent and unified manner and variations identified and considered.
- (d) Nuffield Hospitals has established for each of its hospitals a system, the "Best Practice Initiative", to identify a norm of treatment for each common procedure based upon the informed clinical opinion of the specialist doctors and others involved and which then monitors actual treatment delivery against that norm. While this is a very positive development it is limited to the clinicians and activity in a particular hospital and would benefit from the increase in scale which would result from a national institution covering all hospitals including the NHS.

(e) Recommendations

It is recommended that a national body be established to identify, publish and review on a regular basis what is believed by expert opinion to be the optimum treatment for all commonly occurring conditions requiring specialist and hospital care. A unified system to measure the delivery of treatment against these norms should be established.

COMPLAINTS PROCEDURE

8. (a) It is believed that patient satisfaction with the quality of healthcare received in hospitals in the private sector is very high. Within Nuffield Hospitals this is measured by systematic comprehensive surveys of patients using independent contractors. Nevertheless, on occasions individuals are dissatisfied with some element or other and wish to complain. Generally these matters can be resolved quickly and at a local level in each hospital. Within Nuffield Hospitals, those that cannot be resolved at this level may be referred directly to the Group Chief Executive. If the matter is of some major significance and the patient has suffered some real loss or damage then it is always open to them to seek redress through the courts. However, this is completely inappropriate for the vast majority of situations. When patients do wish to complain about some aspect of their treatment they can sometimes experience difficulty in obtaining a comprehensive and positive response due to the fragmented relationships of GPs, specialists, independent contractors such as chiropractors and osteopaths, hospitals and medical and other insurers. Positive cooperation between these interested parties is usually the norm in dealing with a complaint but it cannot be guaranteed in all cases at this time.

- (b) This difficulty could be overcome by a requirement upon all parties to adopt a minimum standard of complaint procedure as a requirement for a licence to operate as a healthcare provider or associated insurer.

25 March 1999][Continued

- (c) The minimum standard of complaints procedure should include a requirement to cooperate with other interested parties to resolve complaints. There should also be a facility at the ultimate level for independent review of the complaint with the ability to bind all parties to an outcome and judgement.

- (d) Recommendation

All providers of healthcare, including independent practitioners, specialists and hospitals should be required to participate in a system of complaints resolution which meets minimum standards and which provides at the ultimate level for an independent review facility which has the ability to bind all parties to an outcome and judgement.

Memorandum by Community Hospitals Group

PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 59)

EXECUTIVE SUMMARY

1. Community Hospitals Group plc (CHG) was established in 1981 and owns and manages 21 independent hospitals treating over 215,000 patients a year.

2. CHG believes that new legislation for the regulation of independent hospitals should be based on the principle of an independent national inspectorate. The present registering authorities are too small to have sufficient experience for a fully professional and consistent registration policy and much of that experience is based on nursing homes. CHG believes the regulation should include NHS private units.

3. Much of the growth in the independent sector will arise from services at present unregulated. CHG believes this could represent a considerable risk of harm to patients.

4. CHG monitors its performance through the inspection by local health authorities, through a quality assurance process based on external accreditation, and on patient feedback handled through an independent agency.

5. Good clinical governance and in particular clinical audits are improving all the time. Although CHG has legal powers deriving from the granting, removing and limiting of practising privileges, good clinical governance requires the full co-operation of the Medical Advisory Committee and Consultants generally. CHG find that where there is a local culture of active and enthusiastic participation this is reflected in both the public and independent hospitals in that locality in equal measure.

6. CHG is introducing a new complaints procedure which includes the handling of both services and clinical complaints. It will involve, at its final level, reference to external independent legal or medical assessors whose decisions are final. The Company is taking an active part in the development of the Code proposed by the Independent Healthcare Association. When this comes into operation, CHG will use the IHA Independent Review Panel instead of its own assessors.

1. Community Hospitals Group

1.1 This submission is from Community Hospitals Group plc (CHG). Our comments are limited to areas in which we have direct experience, predominantly in the field of acute elective surgery.

1.2 CHG was established in 1981, initially to invest in local independent hospitals which were being developed at that time. The Group now specialises in the management of the 21 independent hospitals it owns. CHG is the fourth largest independent hospital group, having acquired Independent British Healthcare plc in January 1998.

1.3 CHG hospitals are spread throughout England and range in bed size from 15 to 72 beds. The Group is the only publicly quoted independent hospital group and over 86 per cent of its shares are owned by financial institutions (pension and insurance companies, banks, etc). The Group operates three Inland Revenue approved Employee Share Schemes which encourage employee share ownership.

1.4 CHG hospitals treat over 215,000 patients every year.

2. Regulation

2.1 Present regulation derives from the 1984 Registered Homes Act (RHA). CHG supports the principle of careful inspection and regulation of medical services, but believes that there are aspects of the present arrangements which militate against a fully professional and comprehensive scheme. There are three areas where our comments may be relevant.

2.2 Hospitals also operate within Health & Safety and environmental and other health regulations.

*25 March 1999]**[Continued]**Hospitals*

2.3 Since the RHA was framed with nursing homes in mind, it has difficulty in encompassing hospitals. This arises because many registering authorities are too small to have the experience required for a fully professional and consistent registration policy. They may have only one or two hospitals under their control. Further, the experience from which they can draw is largely derived from their registration of nursing homes. CHG believes it is important that the inspection service for hospitals should be based around an independent, national Inspectorate.

2.4 It would be appropriate for such a service to cover private beds in NHS hospitals on the same basis, since at present these are not subject to comparable controls. The proposals for CHI presently anticipate a review every "three to four" years as part of the total NHS Trust inspection arrangements; this compares with twice yearly reviews for the independent sector.

2.5 We have had recent experience of the inconsistencies in the current system as part of our lease of the private patient facilities at the Kettering NHS Trust (The Fotheringhay Suite).

The Suite had been functioning as an NHS private unit but when it came to be inspected, the Registration Authority identified numerous defects which had to be addressed as a condition of registration as a private facility. The Authority's assessment was, in our view, quite correct, but the episode illustrates the different standards that develop when there is no comparable inspection of NHS private facilities.

Nursing Homes

2.6 The majority of inspections by the registration authorities cover nursing homes. They have therefore a richer experience in this field, though there may still be problems of consistency among authorities. However as CHG currently owns and manages only one nursing home, we do not feel that we have enough direct current experience of the process to identify any changes that should be made.

Unregulated establishments

2.7 The growth of unregulated establishments is of increasing concern. Experience in the United States is that the trend away from hospitals, as the sole focus of acute care delivery, will continue. Complementary alternative medicine, cosmetic surgery, additional procedures in GP surgeries, walk-in primary care facilities at railway stations, sports injury, clinics, and physiotherapy are examples of care delivery outside normal "hospital premises". Most of these services are likely to be paid for privately and will therefore represent a considerable development of the independent sector.

2.8 Regulation of these establishments/services is regarded by CHG as important, both because they could represent a considerable risk of harm to members of the public, and also because any inadequacies among them will have a deleterious effect upon the perception of independent healthcare as a whole. CHG acknowledges that the regulations applied to hospitals are unlikely to be suitable for these establishments/services, but believes that they should be brought within the scope of a new Act.

3. MONITORING & INSPECTION OF PERFORMANCE

3.1 CHG has quality control initiatives in place which ensure that patients receive a high standard of service within CHG hospitals. These controls also encourage the early identification of any problem within a particular hospital, giving the hospital manager an opportunity to resolve the problem quickly.

Inspection by local health authorities

3.2 Each local health authority has the statutory power to inspect nursing homes and independent hospitals. This inspection is based on standards set out in regulations under the 1984 Registered Homes Act, local health authority guidelines and guidance issued by the Department of Health and recognised National Bodies. The standards are rigorous, although in our experience the quality of assessment is mixed, a point which is dealt with earlier in our submission.

25 March 1999][Continued

Quality System Framework

3.3 As recognised and widely used by many companies in various industry sectors, all CHG hospitals use the European Foundation of Quality Management (EFQM) "Business Excellence Model" as a quality assurance process. This self-assessment model provides a framework for judging performance on all aspects of services offered within CHG hospitals. CHG will be seeking external EFQM accreditation by the end of 1999.

3.4 All CHG hospitals will be accredited as Investors in People by 31 December 1999 which will formally demonstrate CHG's commitment to developing all the Group's employees.

Patient Feedback

3.5 When patients are discharged from hospital, CHG sends inpatient and daycase patient satisfaction questionnaires via an independent agency. This gives each patient an opportunity to comment on all aspects of their care and service received whilst in hospital. The average satisfaction rating score achieved in these questionnaires is in excess of 80 per cent. Any negative written comments contained within the questionnaire responses are automatically treated as a formal complaint and are investigated as such. The hospital manager is immediately informed of the complaint in order to rectify the problem expeditiously.

4. CLINICAL GOVERNANCE

4.1 In our experience, Consultants and medical specialists, whilst they value the independence which they enjoy in their private practice, recognise that good clinical governance will require more institutional oversight and peer review of their activities. Consultants are working with CHG hospitals to ensure standards of clinical governance are aligned with the NHS.

4.2 In common with many independent hospitals, the Consultants who practise at each CHG hospital are mostly employed at one local NHS Trust hospital. Medical practice and culture at the independent hospital normally reflect the Consultants' local NHS Trust experience.

4.3 Consultants and medical specialists practising in CHG hospitals do so within a framework of rules regarding granting, removing and limitation of practising privileges and other important disciplines (including consent and medical record keeping). Each hospital has a Medical Advisory Committee (MAC) which advises CHG on medical standards and monitors performance. The MACs comprise of representatives of surgical and medical specialties at the hospital. The Chairman is elected from the appointed representatives. The MAC advises the hospital manager on policy changes relating to the provision of medical services and on implementing high clinical standards. There is also a Professional Review Committee comprising the MAC Chairman and at least two other MAC representatives.

4.4 CHG has encouraged and promoted the development of medical audit at all its hospitals. Where there is a local culture of active and enthusiastic participation, our experience is that this is reflected in the outcome in both the public and independent sectors.

4.5 The Chairmen of CHG hospital MACs meet annually. This forum is used to discuss and agree the approach to group-wide clinical governance issues.

5. COMPLAINTS PROCEDURES

5.1 CHG has consistently sought high standards in its complaints procedures. As an independent service provider, CHG is disciplined by the market: the patient, the insurer (where relevant), the GP and the consultant all have the freedom to choose to go elsewhere, should any of them consider that service standards warrant such a move. CHG welcomes and encourages complaints by customers or their representatives, as a way of ensuring that problems are dealt with and that the company remains highly regarded by the market. Nevertheless, the formal complaints procedures need constant improvement and updating.

5.2 The development of complaints procedures in the independent sector has been greatly influenced by a factor which distinguishes independent medical care from that in the NHS. Consultant users are self-employed principals in their dealings with the independent sector hospital providers. There has, therefore, historically been a much stronger distinction between clinical complaints, for which the consultant is alone responsible, and those complaints which relate to the hospital's staff and facilities. In certain circumstances, complaints may be matters of joint responsibility. Traditionally, patients with clinical complaints have been referred to the consultant concerned. This process is one which has been supported by the insurers and the medical defence organisations.

5.3 Until early 1998, therefore, CHG had fully established complaints procedures in each of its hospitals, each of them making this distinction. They were sensitive and largely effective, but we acknowledge that they did not have an external, independent review element as a final point of appeal. In the recent past, the culture

25 March 1999][Continued

has changed. Independent hospitals have been reconsidering the traditional distinction. It has been necessary to bring medical and insurance opinion along with us. During 1998, CHG has taken the opportunity afforded by the need to develop a single procedure common to all of our existing and newly acquired hospitals, to produce a procedure which follows the NHS standards as closely as possible. This policy will operate from early 1999.

5.4 The procedure (copy attached as Appendix A)¹² covers both service and clinical complaints. It requires the Manager of the hospital to acknowledge written complaints within three working days, and to investigate and respond within 10 working days. If a resolution is not achieved at this level, the matter is referred to the Chief Executive, who will respond within a further 10 days. If the complaint concerns a Consultant, the local hospital manager will involve the Chairman of the MAC, and they will decide whether this should be referred to the PRC within a similar timescale. If the matter is not resolved it will, as before, go to the Chief Executive.

5.5 CHG agrees that the complaints procedure must contain an independent element which will sustain the confidence of the complainant and the public generally. It is not easy to provide assessors or advisers in cases of clinical complaints who will satisfy the criterion, because they will inevitably be drawn from the medical professions. The CHG procedure provides that, if a complainant is still not satisfied after the Chief Executive has reviewed the complaint, it is referred to the non-executive Directors of CHG and they will decide whether further assessment is required. If they do, they will appoint an independent external legal or professional assessor whose decision will be final and communicated to the complainant. The Board will seek external medical assessors whose distance from the parties involved ensures impartiality and will also include a lay element in the consideration. No part of this process affects the complainant's legal rights.

5.6 The Independent Healthcare Association is in the process of developing an industry-wide Code of Practice for Handling Patients' Complaints. This process has the full support of CHG. When the Code comes into effect, CHG will subscribe to it and the complainant's final point of appeal will be to the IHA Independent Review Panel which will replace the CHG Board's independent, external assessment.

6. CONCLUSION

The changes in legislation currently being considered, provide an excellent opportunity for improvement. The view of CHG is that the independent and publicly-funded sectors will both continue to grow in importance. We should use the opportunity therefore to ensure that the standards of clinical governance and the management of patient complaints are of equivalent high standards in both sectors, and that regulation of all private provision-both NHS and independent, including services not currently regulated-are brought under a common and coherent process of regulation.

¹² Not Printed.

25 March 1999]

[Continued]

Examination of Witnesses

MR BARRY HASSELL, Chief Executive, Independent Healthcare Association, DR ANDREW VALLANCE-OWEN, Group Medical Director, BUPA Hospitals, MR CHARLES AULD, Chief Executive, General Healthcare Group, MR DAVID ERVINE, Chief Executive, Nuffield Hospitals and MR ALAN PILGRIM, Chief Executive, Community Hospitals Group, were examined.

Chairman

273. Colleagues, can I welcome you to this morning's meeting of the Committee and apologise to our witnesses for the slight delay in starting, I am sorry about this. Thank you for your attendance today, and, in particular, thank you for your very helpful, detailed, written evidence, which we found extremely useful, and we are grateful to you for that. Can I begin by asking you each briefly to introduce yourself to the Committee. I do not know who wants to begin; Mr Pilgrim?

(*Mr Pilgrim*) My name is Alan Pilgrim, and I am Chief Executive of Community Hospitals Group.

(*Mr Ervine*) David Ervine, the Chief Executive of Nuffield Hospitals.

(*Mr Hassell*) Barry Hassell, Chief Executive of the Independent Healthcare Association.

(*Mr Auld*) Charles Auld, Chief Executive of General Healthcare Group.

(*Dr Vallance-Owen*) Andrew Vallance-Owen, Group Medical Director, BUPA.

274. Can I begin, having thanked you for your written evidence; we have had a great deal of written evidence to go through, and I have attempted to look in detail at the submissions that you have given us, and there are certain distinctions and differences between each of your organisations, although broadly similar points are also made. We have had a number of worrying accounts of problems that are occurring in the independent sector; to what extent do you feel the sector is currently adequately or inadequately regulated?

(*Mr Hassell*) If I may, Mr Chairman, perhaps I will respond to that. Firstly, can I say that the Independent Healthcare Association welcomes this inquiry, and we would like to ask that it seeks to set minimum clinical quality standards, to widen the scope of statutory regulation, increase its evenness and make it focused on outcomes. Now, I mention that by way of sort of an umbrella comment. I think it is fair to say, as far as the sector is concerned, that there is sufficient regulation already, but what it lacks is perhaps appropriate regulation, and we would certainly like to see the shift of evidence away from an emphasis on facilities and to look at the regulation of clinical practice.

275. Can I just come back to you, you say that there is sufficient regulation at the present time?

(*Mr Hassell*) Yes, there is.

276. Can you qualify that, what you mean by sufficient regulation?

(*Mr Hassell*) Yes, I can. Certainly, as I say, in terms of sufficiency, I am talking in terms of volume, there are probably 150 different Acts of Parliament, regulations, statutes, that cover us¹, so in sufficiency there is a lot there; and, certainly, even under the Registered Homes Act, I would like to make it quite

clear that for ten years the Independent Healthcare Association has been campaigning for changes for better regulation, so we have absolutely no problem sitting here talking about regulation. What we would like to see though is that shift away from, as you know, the Registered Homes Act is frequently referred to as covering nursing homes with theatres attached to them, and, we think it is right, we need to move away from that situation to regulation, which is much more appropriate, moving away from regulating buildings and looking at the regulation of the processes, looking at the outcomes that are involved in hospital situations.

277. Mr Auld?

(*Mr Auld*) Mr Chairman, thank you. I think that, in supplementing that response I would like to draw the Committee's attention to the written evidence of the Department of Health, in paragraph 3.6, where they delineate reasons for the inadequacy of the current regulatory regime, a view with which I think my company, and I believe the Independent Healthcare Association, would agree. The current arrangements have little influence on standards of care; there are few powers other than to decline to register or to deregister an establishment; it cannot, for example, require an establishment to cease undertaking techniques even where the inspectors have concerns. So, I think that in that sense we would be at one with evidence that the Department has already submitted to you. Most importantly for many people, and especially for members of the Independent Healthcare Association, and I quote: "Some treatments are carried out in unregulated premises", and that does give us cause for real concern.

(*Dr Vallance-Owen*) I think that is a very important point, Chairman. We say that we are regulated, the hospitals that we represent here, but there is a great raft of clinics, people calling themselves cosmetic specialists, allergy consultants, a whole range of people, who do not seem to be regulated in any way. It seems that in this country almost anyone can put up their plate and say they have a clinic, and while we, of course, are regulated, those are not, and any regulation that comes through, we believe, should cover the whole range, and, in fact, across both sectors, too. We really do feel that all the people of this country should know that wherever they go for treatment there is a sort of standard set of regulations; and the Quality Framework being put forward by the Department of Health seems to be a very good one, which should be the one which could be made to apply over both sectors.

278. Can I be specific about one area that has struck us all, I think, or certainly struck a number of us, as a tension, inevitably, within the independent sector, that is the tension between objective advice that one might receive, in having a private consultation, and sales techniques, inducing

¹These are detailed in the IHA written evidence, Annex 7.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Chairman Cont]

someone to enter a course of treatment that may or may not be appropriate. And I think all of us have been worried, picking up the last point that you made about the unregulated clinics, by what some might call the cowboys involved in the independent sector, that there is a problem that we picked up, from substantial evidence that we received, of people presenting themselves as "consultants" who are not medically qualified, who are seeing patients initially, in clinics, and making recommendations that they go forward for various treatments, which may well be not necessary. Is that an area that you are concerned about? Mr Ervine, do you want to come in on that?

(Mr Ervine) Yes, Chairman. This is where, I think, we put such huge emphasis on the whole question of clinical governance within the hospitals, that are already regulated, obviously, the whole infrastructure of Medical Advisory Committees, data collection, peer review, case conferences, all those sorts of things, all help to mitigate that particular type of danger. But our concern is that this does not apply across the whole sector, and obviously is voluntary, which is why we would like statutory regulation and compulsory joining in to that type of process.

279. The picture we have got so far has been that the concern about the legislation is its relationship primarily to buildings and similar concerns that one would have in the care sector, or nursing home sector, rather than, as you have said already, the quality of provision. But how does one address this tension between the issue of selling techniques and the actual clinical need for an intervention? I have been to America and looked at what happens in America, there are huge numbers of people who have completely unnecessary operations because of the nature of health care in America. How do you deal with that? How do I know that if I am coming to see one of your people I am not going to get taken into hospital for something that really I do not need to have done to me?

(Dr Vallance-Owen) On that one, Chairman, it is about people, I think, it is making sure that the people who treat patients, wherever they are, are properly qualified, experienced, have the right sort of expertise. Now the General Medical Council, when it comes to medical people, has a specialist register and you can only practise as a specialist in this country if you are on that register, in the NHS and in our hospitals, but there is no force of law to that, there is nothing to stop you calling yourself a specialist, it is not a sort of protected name. One of the things that might be done is to say that you can only put up your plate and practise independently in that way if you are a GMC registered specialist, and that will be one way of trying to get that more enshrined in law rather than in sort of convention.

280. So are you saying that just because a person is registered with the GMC means that they will not put a patient through unnecessary surgery? The cosmetic surgery area is obviously a good example, where we have evidence of people being enticed into having all sorts of bizarre operations, that frankly they do not need, and often they end up coming out looking worse than they did when they went in.

(Dr Vallance-Owen) I am afraid, that probably is right, Chairman, but a lot of the people doing those operations are not specialists, as defined by the General Medical Council, they are not properly qualified specialists, who have been through the full training. All of us, in our hospitals, when we talk about cosmetic surgery that is consultant-led cosmetic surgery, with proper support teams, and all the rest of it, in a proper hospital setting. The sort of people who, I think, you are talking about, largely, are not regulated in that way, either through sort of self-regulation, that we have in the IHA, or through any sort of legal regulation; and that is a real issue, I think.

(Mr Hassell) I think it is important, in this discussion, that we differentiate between mainstream hospitals and perhaps smaller clinics, because I think it is important that the Committee understands that within mainstream hospitals there are Medical Advisory Committees, and those Committees, actually, at the IHA, for instance, in 1993, issued very clear policy guidelines, which is contained within the written evidence we gave you, which means that the MAC and the hospital management should only grant admitting privileges to doctors who are well accredited, with appropriate experience and qualifications. And, furthermore, the majority of referrals, of course, to independent hospitals will be through the GP, who acts as a gatekeeper.

(Mr Auld) Just to underline the concern that we share with the Committee, the past President of the British Association of Aesthetic and Plastic Surgeons was moved to permit his comments in a directly attributed quote in an advertisement, relating to cosmetic surgery, which my company put out in part of the country, re-emphasising the fact that, as he said, and as we published, it is the doctor-patient relationship which is at the centre of surgery, that it should be the *consultant* speaking to the patient and deciding whether surgery is appropriate or not. Obviously, we share that view, because we actually published that in the Daily Mail, to re-emphasise the fact that we are as concerned as many are that unregulated and often unregistered people purport to be medical consultants. They are perhaps less emphatic about the difference between a sales consultant in a white coat and a medical consultant, and that is a real concern. Our advocacy is that that should be regulated. I think we are very clear as to what the outcome of that should be.

281. So what you are saying to me, and obviously this relates very much to how we improve regulation, is that within the organisations that you represent I would not have the experience of being taken into a hospital and having some surgery that an objective evaluation of my case would deem I did not need? You are all saying, quite categorically, that would not happen within your organisation?

(Mr Auld) Yes. If I may say so, Mr Chairman, the key thing about this is that what we would adhere to is conventional, in this as with any other elective surgery carried out in our hospitals. The way that you, as a patient, came into one of our hospitals would be the same route as if you had gone into the National Health Service. You will have visited your GP and your GP will have sent you to a consultant. It is at that point, with your consultant, that you would

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Chairman Cont]

either go into the National Health Service hospital, or, if you deemed it appropriate and he deemed it appropriate, into the private hospital. Importantly, the vast majority of procedures in the independent sector occur as a consequence of a totally conventional referral route, identical to that which pertains in the National Health Service.

282. A number of my colleagues, I know, want to come in on this area, which is a very important area; before I pass over to them and they pursue in more detail some of these areas, can I ask you specifically about the position in terms of the protection of a patient whose status changes during a course of treatment, and I have picked up, on occasions, difficulties with constituents, who have been, at certain points in their treatment, private patients and then NHS patients as a consequence of the way in which they have been referred, usually to a consultant privately. And I was interested in, I think it was, the CHG evidence, that, in common with many independent hospitals, the consultants who practise at each CHG hospital mostly are employed at one NHS Trust hospital; so the majority of people that you have employed in your hospitals are the NHS part-time consultants, presumably?

(Mr Pilgrim) Yes.

283. Now what has caused some interest in this inquiry, in the evidence that we have looked at so far, and certainly in my own experience of dealing with constituency problems, has been the way in which the status of the patient is sometimes confusing, particularly where there is something going wrong, in that a patient may have gone in and had a different status at different times, but something went badly wrong somewhere, and depending on where they were at the time it went badly wrong, despite it being part of a whole process of treatments, their rights to access to complaints procedures, inspection, etc., seems to vary. Do you follow the point I am making, which is, we picked up in evidence that, because patients do not just become private or NHS, frequently patients flit between both areas, quite often?

(Dr Vallance-Owen) I do not think frequently, Chairman.

284. Well, it does happen.

(Dr Vallance-Owen) We have worked out that we treat about 850,000, or we do about 850,000 cold, elective operations, amongst all the other things that we do, every year, and the number of patients who actually end up transferring unexpectedly is tiny, obviously, sometimes there is a transfer which is expected, and they remain a private patient, if they go into an NHS Trust for radiotherapy, for instance, but they do that as a private patient, and that is paid for. I think you are talking about the sort of patient who maybe unexpectedly becomes ill and needs to be transferred, and out of all those episodes the last evidence we had from Professor Brian Williams was, in fact, in 1993, but he discovered only 131 patients in that year who had transferred in that way into the NHS. Now he is about to publish more figures, but we have heard from him verbally that the sort of proportion of the number of transfers has not really changed much, so we know that this can be an issue but we think it is a terribly, terribly small issue, in

terms of the overall number of patients that we treat. Consultants always try to make sure that the patient they are treating is in the right hospital, and they would never put someone in a private hospital without an intensive care unit, for instance, if that patient might be likely to need ITU, and, of course, if they are in an NHS Trust, and 20 per cent of private patients are treated there, in any case, then it is all covered in any case, they do not have this transfer issue.

(Mr Hassell) I wonder, Mr Chairman, if I may follow up on that point, because you obviously raised a number of points in your question, and I could see where there could be some confusion, as Andrew said, in the private patient work that takes place in the National Health Service, the starting-point there, which, it might surprise the Committee to know, is that, unlike mainstream independent hospitals, private patient work in the NHS is not regulated, in spite of its volume. And, I have to say, it is no more than anecdotal evidence, but I could see how the confusion between the status of a patient could arise within private facilities in the NHS; within the independent sector, I think, the lines are fairly clear-cut. Just one final point, if I may, which I think is an important one, regarding the issue of transfers from the independent sector back into the NHS; there is actually a requirement, under a Statutory Instrument in 1984², that requires hospitals to make arrangements for admission to NHS facilities where there is an emergency. So there is actually a requirement on us, under statute, to make those transfers, should it be necessary.

285. Can you confirm that the status of a patient who is placed by the NHS under contract in a private hospital is different from the status of a patient who is in there, through choice, as a private patient; in terms of regulation, I am talking about?

(Mr Hassell) In terms of regulation, the status of an NHS patient in an independent hospital, if you like, is two-fold; they will be covered by whatever regulation covers the independent hospital, and any NHS rules concerning the complaints procedure would automatically be followed through, as a right, for the patient, into the hospital.

Chairman: That was the point I was making.

Dr Stoaite

286. Let me pick up a point that you raised earlier, actually a very important point, and that is whether there is any chance of a patient going to see a consultant privately and ending up with a treatment that perhaps was not necessary or appropriate. I am not so worried about the quality of the treatment or the qualifications of the person who has done the operation, they may be absolutely first class, but there is no question in my mind that there is a difference in threshold between the treatment likely to be received. And my experience as a doctor for over 20 years is that somebody, for example, seeing a consultant privately is more likely to have an operation than they would do on the NHS, for example, a woman with period problems is more

²Statutory Instrument 1984/1578, Regulation 12 (2)(d). See also NAHAT Acute Hospital Inspection guidelines.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Dr Stoate Cont]

likely to have a hysterectomy, a child with tonsillitis is more likely to have tonsils and adenoids removed, a child with glue ear is more likely to end up with grommets, and that is certainly the experience I have had over many years. Now whether that indicates overtreatment by the private sector, or undertreatment by the NHS, I think, is actually a fascinating point, and I would like to hear your views on that?

(Dr Vallance-Owen) Yes, your last point is certainly relevant, in terms of that. But one of the problems we have is that, and we all, as you have heard, believe that consultants practise ethically, professionally, correctly, wherever they are working, whether it be in the NHS or in the private sector, we obviously believe that, that is what happens in our hospitals; but the answer is, actually it is very difficult, we do not know, because there is not sharing of data. And one of the things we are trying to suggest here is that common regulation would mean, inevitably, sharing of data on performance, activity of consultants, wherever they work; at the moment, it is very hard for us to know what our rates of intervention are, compared with the rates of intervention in the NHS. We are actually aware of the supposition you have put forward, it is almost impossible to prove, actually; so we think that sharing data and common regulation will enable that much more.

Dr Brand

287. I was going to pick up the same point Howard did. Mr Auld sort of painted a picture that I recognised when I started in general practice 30 years ago, of the private sector only accepting patients if they were referred through a GP. I am afraid that, nowadays, that is almost becoming an exception, most consultants will accept direct referrals from patients; if they are courteous they will inform the GP that they have seen them, or that they have done something to them. And I would be interested to see on what figures you are basing the assertion that the traditional pattern of referrals still exists. The other point is that Dr Vallance-Owen makes a very valid point, but surely that is in your hands to make sure that that happens. NHS hospitals can insist on interdepartmental peer reviews, and that sort of thing; there is absolutely no reason why the private sector, as the people that enable consultants to carry out their work in your premises, why you should not insist on peer review and publishing of data, and that sort of thing?

(Dr Vallance-Owen) Two points there, through you, Chairman. First of all, the GP referrals. I must say, I am quite worried by what you suggest, because I think we all believe that, by and large, patients are referred by GPs.

288. Have you got evidence for this?

(Dr Vallance-Owen) The only evidence I have is from the insurance side, where we insist that a patient says, on a form, when they are being referred for claiming, that they have been referred by their GP, so we do insist on this, it is a — /

289. I am sorry, Mr Chairman, the form has got two boxes, one that can be signed by the GP, the other one can be signed by the specialist.

(Dr Vallance-Owen) That is a question of signature, but they have to sign themselves to say that they have been referred by a GP. So we believe, and we certainly believe, that patients should be referred by their GP, we are very anxious to maintain that system, it is an important one to us. I have now just lost the second point you made.

290. The peer review, and your ability to actually enforce that?

(Dr Vallance-Owen) We are doing, all of us, a huge amount. I think you will have seen, in evidence given to you by the Royal Academy of the Colleges, a private practice clinical Quality Framework, which describes what we are all doing, we have all signed up to this, across the sector, and it picks on a lot of things which we are doing in any case, but also says what we will be doing by the end of the year, it mirrors almost exactly the clinical governance arrangements in the NHS. And peer review is a crucial part of the role of all of our Medical Advisory Committees, and, increasingly, they are aware of the need for that, given all the other things which are happening.

(Mr Pilgrim) Dr Brand, if I can come in, I do not recognise the picture that you paint regarding consultant referrals. Certainly, in our Group, the vast majority of patients present for their outpatient appointment with a letter referring them from GPs. Increasingly, consultants are now practising totally in a private hospital. I think, years ago, they used to practise, some of them, from consulting rooms away from hospitals, but increasingly all of our hospitals are adding outpatient consulting rooms, and all of our routine practice is about making sure that the patient has a GP referral letter in the file to be presented to the consultant at their initial visit. So it is not a picture I recognise, frankly.

Dr Brand: I find that very interesting. It would be nice to have some hard evidence on that. Because, of course, you do advertise direct to patients, which runs across that, as a suggestion.

Mr Lewis

291. I would like to come in on this point because I am not convinced either. The basic question would be, you refer to advertisements in the Daily Mail; now I assume, therefore, you are marketing your product, each of your organisations is marketing its product directly to the public, and, therefore, I would accept you need to do that and then the patient would go along to the GP and say "I saw that form of treatment in the Daily Mail and I would quite fancy that, I think I might need it", and the GP would say "Okay, we will refer you to the appropriate organisation." The trouble is, a number of your organisations also employ, as I understand it, sales people, who are actively employed to actually sit down with patients and talk about the products that you have available; is that true, do any of your organisations employ such people?

(Mr Irvine) No.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Mr Lewis Cont]

(Mr Pilgrim) We have what you might describe as a sales person, and their role is to communicate directly with GPs regarding the services available. And, frankly, what we are trying to sell is Community Hospitals Group services rather than Nuffield Services or BMI services; we have no interest in overservicing, that does not do the independent sector any good and it is not the basis under which our organisations were established.

292. So in each of your organisations' cases the patients that your consultants see are referred by GPs; that is an accurate statement?

(Mr Pilgrim) Yes, the vast majority.

293. So when do you discriminate, when do you say it is okay if there is not a GP referral?

(Mr Ervine) Certainly, the major area, I think, would be in health screening, which is self-referral, the individual company, often, or an individual will say "I want to have my two-yearly check-up", or five-yearly check-up, or whatever it is, and the report goes back to the GP, but it does not come through them first.

294. So within each of your organisations you have clear protocol and policies, which identify when it is acceptable for your specialists to see patients without a GP referral, within each of your organisations you have clear policies and standards laid down when it is acceptable to see a patient without a GP referral?

(Mr Ervine) And so much so, Chairman, that we have recently set up quite a complicated arrangement to actually facilitate patients going back to their general practitioner, if they actually ring us up direct and enquire about something, there actually is a standard protocol which explains to them what they have to do, to make an appointment with their general practitioner, who will then advise them and refer them on. And we would like to think the GP would refer them back to us if it was clinically necessary; but that whole step is in there just to cover that particular point.

(Dr Vallance-Owen) Quite apart from anything else, through you, Chairman, it is the professional convention; if consultants started treating GPs' patients without telling them, we would have trouble with the GPs, who are the referring doctors. So the consultants want to work with local GPs, they want to work with them and build up a good relationship, it is not in their interests to start taking on patients without referral.

Chairman

295. What about the walk-in GPs, where does that fit in with you; how many referrals are coming now from the walk-in GP surgeries, on the stations, or wherever?

(Dr Vallance-Owen) I think, tiny numbers of those.

296. This is a new development; but how would you feel about receipt of referrals from a GP in those circumstances?

(Dr Vallance-Owen) Certainly, when we got involved in that, in a pilot scheme, we were very strict in terms of the GP, the private GP, had to involve the NHS GP before a referral was made; that was very much the criterion that we laid down.

297. Would that apply to the other witnesses, as well?

(Mr Ervine) I do not think we have addressed it, frankly, Sir, and we have not come across that particular phenomenon, frankly.

(Mr Pilgrim) We certainly have not had any referrals from a walk-in GP and we have no private GP services of our own.

(Mr Auld) An anecdote of one, Mr Chairman. I actually did have occasion to have a very small procedure done, the removal of a small lesion on my hand. So I actually took the opportunity to go into one of these walk-in clinics and, therefore, to experience at first-hand what happened. I was seen by a GP and I was referred to a hospital, I was able to check with my own GP, who did actually receive a note, that a proper referral note went through to the independent hospital that I was referred to. So I can personally confirm, on sample of one, that the system did actually work; and, by the way, I was anonymous. No-one at that centre knew, of course, that I had more than a passing interest in having a small wart removed.

Mr Amess: I apologise that I have to go at 11.30, I have a Trade and Industry question, and I am sorry that I cannot hear the rest of your evidence. I am advised that 23 per cent of my constituents in Southend West have private health cover, I do not, so please do not charge after me at 11.30, trying to flog me cover, I cannot afford it, but my aged mother does have HSA cover. I do not have a private hospital in my constituency but I do have a number of people operating privately and I do have 120 private nursing and residential homes, big areas for me. I just wanted to put three general questions to you, and I apologise, Mr Chairman, if this messes up the line of questioning. The first is, quite obviously, there are a number of hospitals which have private beds and private wings; just to help me, as an individual, I wonder—

Chairman: In NHS hospitals?

Mr Amess

298. Yes, sorry; if you could give me some indication how that trend is going, what is the situation at the moment? The second thing, your sector is often criticised for poaching nurses from NHS hospitals, it is often said that the NHS, with the scarce resources that we have available, is training these nurses, they do all the work and then you just snatch them away, which is not helping the NHS sector. And the final thing, it was specifically about something which happened in the House of Lords last week, the House of Lords voted to give the Secretary of State the power, by regulation, to extend the duty of quality for each NHS Trust, and the functions of the Commission for Health Improvement to any independent hospital. Do you actually believe, gentlemen, that this is the way to regulate the independent acute sector, or would setting up a new body, the independent inspectorate, as far as you are concerned, provide the best solution?

(Mr Hassell) Shall I start. Firstly, let us make it clear, nobody is going to charge after you, or anybody else; we represent the hospitals, not the

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Mr Amess Cont]

medical insurers, let us be clear about that. I was interested your mother is a member of HSA, because, I think, if I may, Mr Chairman, point out some numbers that may interest the Committee, and that is, there are about seven million people in this country who are covered by private medical insurance, but, interestingly, there are a further six million people who have cash benefit schemes, such as HSA, so about 13 million people choose to pay additionally for their health care, about almost 50 per cent of the working population, but I will leave that to one side, if I may. Pay beds and private patient units in the NHS, I touched on those a little earlier, and there are, I believe, about 70 dedicated private patient units in the NHS, plus there were up to 3,000 pay beds in the UK, these are variable beds, within an NHS hospital. There are many areas in the pay bed scenario that concern us, and, it may interest you, Mr Chairman, because of your earlier question, not all of the dedicated units, of course, will have separate theatres, so that certainly raises some interesting questions. And one of the things which I am not clear about is, for many, many years, there was something which I think was referred to as the six principles, which used to govern the access of private patients into the NHS facilities. I have to say, I do not know whether that system is still applied and monitored, and perhaps you know the answer to that.

(Mr Ervine) Can I pick up the nursing training bit; two aspects to that, I think. I agree, it is an oft-quoted shibboleth, which I think we can nail, fairly effectively, if I just talk about Nuffield Hospitals, certainly, and my colleagues can add anything if they want to. Just to give you the context of this, last year Nuffield Hospitals recruited 287 nurses, of which approximately half, 150, came, one way or the other, from the National Health Service; but, at the same time, 85 nurses went back to the National Health Service from our hospitals as well.

Chairman

299. Had you trained those nurses?

(Mr Ervine) Yes; thank you, Chairman, for that prompt.

300. So you took them through basic nurse training?

(Mr Ervine) No, not necessarily, but we might have done the ENB conversion course for them.

301. Where were they trained then?

(Mr Ervine) Pre-registration training, I could not quote for you, but certainly nurse conversion courses we have done. But the other thing that we have got in the sector, and in Nuffield Hospitals in particular, is our own nurse training school, which gets ENB recognition and nurse degree recognition, and that provides training courses for a whole variety of things, including operating theatre management, operating department practice, return to nursing, teaching and assessing clinical practice, managing clinical risk, all those sorts of things. Now, interestingly enough, 15 per cent of the people on those courses come from the National Health Service, they actually use that training facility.

302. Let us just talk about pre-registration and perhaps extend this to medical training as well. What figures do you have on your involvement in medical training?

(Mr Ervine) Nurse training, we participate in the Project 2000 training of nurses on site. I have not got an exact figure, but I think, last year, we had something like, no, not last year, but over a period of time which I cannot quantify we had something like 2,000 students in total came to us from the National Health Service.

303. I am slightly concerned that we are getting off the general area of questioning, but I am interested, perhaps for possibly different reasons from Mr Amess, in the extent to which the private sector trains people?

(Mr Pilgrim) I think, our record, in terms of post-registration training stands up to excellent scrutiny.

304. Post-registration you are talking about; what about pre-registration training?

(Mr Pilgrim) Pre-registration training, I believe that the independent sector is no different from any other industry which recruits people who have been trained elsewhere.

305. So, basically, you are saying, you rely on the National Health Service to train the people that you recruit?

(Mr Pilgrim) But we are no different, Mr Chairman, with respect.

306. Yes, or no; do you? I do not want to spend too much time on this, because it is not directly related to what we are looking at, but I think there are two sides to the picture here, and I think we need to know from where you recruit these people; are they trained in the NHS, basically, yes, or no?

(Mr Pilgrim) Half of our people have been, yes, about the same as Nuffield, half of the people that we recruit will have been recruited from the NHS, but we would not see that as being any different from the situation of any organisation which is recruiting graduates, which is recruiting qualified accountants, who had been trained by somebody else, or solicitors who had been trained by another firm.

(Mr Hassell) May I make a couple of comments. Firstly, I think it is quite a well-reported fact that quite a number of nurses, when they leave the NHS, are considering leaving nursing altogether. I would like to argue that, by retaining them, scarce resources, within the independent sector, we are actually retaining them for the Health Service, the mixed economy that we have, effectively, in the UK. I think, the other point, which you may recall from your own recent report, when you were looking at NHS staffing issues, I think Christine Hancock made quite an important statement³, which I think is in your report, explaining exactly why nurses leave the NHS and why they like working in the sector, and I do not think I could improve on her statement.

Chairman: I intervened on Mr Amess' question, for reasons that are fairly obvious. I do not know whether you want to pursue it any further, David.

³Health Committee, Third Report, Future NHS Staffing Requirements Vol 1, paragraph 63.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

Mr Amess

307. Can I have my answer to the House of Lords question?

(*Mr Auld*) Probably more than one of us would like to comment on that point, Mr Chairman, because I think it is something that we have all been following with very lively interest. I think it is fair to say that, we are noting with great approval the sort of discussion that is going on, as reported in Hansard, because I think a lot of what is being discussed, in respect of the independent sector's involvement with NICE and with CHI, is something which we see as being very relevant to the deliberations of this Committee and very close to our hearts as well. We would be in great support of the main thrust of what is being said, as you have probably detected from the weight of our evidence. In respect of the Government's responses so far on this, I think that while we obviously see some hesitation at this point as to how it will finally turn out the spirit of the involvement of the independent sector in regulation that is identical to that of the National Health Service in all substantive and relevant elements, of course, is something that we view with great approval and would absolutely endorse.

Chairman: Before any other witnesses comment, I know that Dr Stoate wants to pursue this in a moment or two, are you happy with that, for the time being then; can I bring in John Austin, who has been trying to get in, before I move on to Dr Stoate, to look in more detail at those areas that you have touched on.

Mr Austin: There are two points I want to pick up on the immediate discussion. Would I be right in saying that you feel you represent the quality end of the private sector, in health care?

Chairman: That is a loaded question.

Mr Austin

308. And, if so, do you think that what you said about your relationship with GPs and GP referrals applies generally throughout the private sector, or is it less well developed elsewhere, and I am thinking particularly about self-referral as well, in terms of the adverts that we hear on the radio, or whether it is for new and wonderful hernia techniques, or whatever, where people just ring up and come in?

(*Dr Vallance-Owen*) This is the completely unregulated sector that we were talking about earlier on, in which I think maybe that does happen, and it does need to be regulated.

309. Dr Vallance-Owen, you said earlier, you expressed a concern, which is one I know concerns some of my colleagues, and certainly concerns me, about the person who can just stick up a plate and call themselves almost anything, whether it is therapist, or consultant, or whatever. If you feel that that area should be regulated, have you or your association had any thoughts about how you might actually define what is a therapy or a treatment for the purposes of regulation?

(*Dr Vallance-Owen*) I think, probably, we have not, in any detail. This is a huge area of discussion, but we were talking particularly about people, in what I was just saying, earlier on, I was talking

particularly about people who call themselves specialists, of whatever type, and I think that is an easier one than when you start getting into other types of treatment altogether, which are not, say, requiring a surgical or a medical intervention, complementary therapies and other types of things. We have read this week that there is now talk about regulation in that area as well, and I think that would be a good thing.

310. And invasive investigation?

(*Dr Vallance-Owen*) I would hope that, if it were invasive investigation or surgery, it should certainly be a specialist as defined by the GMC, absolutely.

311. Can I just pursue briefly a point from the Chair's comment. How would you feel about the suggestion of a training levy being placed on the private sector, with possible rebates to the quality end of the market, like yourself, that does provide some training?

(*Mr Hassell*) Can I make a comment there. I think, in some respects, what we would welcome is to see the training budget moved from, sort of top-slicing within the Department's budget to be moved to the DfEE, I think that would be a far more appropriate place for the training of, if the country decides that it needs doctors, nurses and other professionals, why not have the training under one umbrella Government Department, which is specialised in handling those needs. I think that is a way forward. The issue of whether a levy should be applied to our sector, I think, raises huge questions for the rest of industry in the UK, particularly, as Mr Pilgrim said earlier, the state, of course, funds all higher education, and very few people who are funded through that higher education system actually end up by working in the state sector, and you can think of many examples yourselves, I am sure. I think, on your general point, if I may come back to Mr Austin, at the beginning, I would like to repeat what I said earlier, and that is that there is a need, I think, in our discussions about regulation, and indeed on the whole issue of GP referrals, to differentiate between mainstream acute hospitals, which my Association represents, and some of the smaller clinics, some of which may be regulated, others may not be. But I think it is important, as Andrew said a moment ago, that, within the areas of concern you have, if there are ever any suggestions of inappropriate treatments being given then the GMC is certainly the route through which anybody that has evidence should refer it.

Dr Stoate

312. Just picking up on something that Mr Amess has already raised, just to clarify; this report, last week, about the Secretary of State possibly setting up an independent inspectorate to monitor the activities of the private sector, and, of course, further than that, to require hospitals to provide annual reports, are you broadly in agreement with that?

(*Dr Vallance-Owen*) We are, very much so, because we feel that, with nearly 20 per cent of private patients now being treated in the NHS, quite a lot of NHS patients being treated in private hospitals, consultants very much with a foot in both camps, it is absolutely logical that there should be one,

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Dr Stoate Cont]

overarching regulation, and that the Commission for Health Improvement would sensibly overarch over both, rather than a consultant, as soon as he walks down the corridor, to the pay bed unit, or something like that, not being covered. Surely, it is all that consultant's practice which should be covered, and all the people of this country should know what sort of a common regulatory system there is, wherever they are treated.

313. Okay. So, to pick up on that, to go back to an earlier question, about whether the private sector is overtreating people surgically, or whether the NHS is undertreating them, and you say you do not know; does that mean that you would be happy then to follow the guidelines and parameters of best practice set up by NICE, for example, would you follow those?

(Dr Vallance-Owen) I think this is a very important point. I think we have already shown that we do, where there is a consensus, like, for instance, over breast cancer guidelines, where there is a national consensus on that, we, I think, all of us, now, are applying those in our hospitals and making sure that only consultant surgeons who treat breast cancer are looking after our patients, working with multi-disciplinary teams, that is an example before NICE. Now NICE, hopefully, is going to do much more of that, it is going to produce guidelines on what is best practice, common, agreed clinical guideline practice standards across the whole of the country; and, of course, we would want to draw upon that best practice and encourage that in our hospitals.

314. So, for example, what would happen then if NICE produced a report on the treatment of glue ear in children and said that, for example, grommets were now a waste of time and recommended that grommets were used only in very specialised circumstances, or preferably not at all, would your consultant specialists be happy to say "Okay, we'll stop doing grommets"; because, currently, they do a lot more grommets, in my experience, than they would do on the NHS?

(Dr Vallance-Owen) I think the key thing here is information and informed choice. The important thing is that that information is made accessible to the patient, and we would certainly want to encourage consultants to walk through that information, the pros and the cons of any such treatment, so that the patient, or the parent, in this case, would know what they were getting themselves into; and that is the important thing, in our sector, informed choice. But if NICE is producing guidelines which say what is right and what is cost-effective then that should very much be part of what we are looking at, too.

315. Would you be prepared then to limit your range of treatments that you provided in your units to the NICE parameters, or NICE guidelines, or would you still want to range beyond those?

(Dr Vallance-Owen) I think, in a private hospital, we would want to encourage the consultant to walk through these issues with his, or her, patients. I think, as a health insurer, that is quite different. We are in a very similar position to a purchasing commissioning

authority; there we are wanting to be managing all of the money for all of our members in a cost-effective, appropriate way, and that is a slightly different area.

(Mr Auld) Could I just enlarge on that. I think a lot may turn upon whether or not the Government decides to make what at present are guidelines, within NICE, mandatory. It is quite important actually to see what comes out of that aspect of deliberation. That is important because, quite clearly, if the guidelines, become mandatory then the position really is very clear. It is made clear for everyone; although, across the whole range of medicine, I think it is going to be quite a long while before NICE is going to be definitive on everything. Outside of that, assuming that the guidelines are just that, this is perhaps more of the grey area that you are touching on. I think that is the area where the role of the Medical Advisory Committee and the role of the clinical governance framework that each hospital within our Association will have will start to come into play. In the event that there is a consultant who, as many do, will take a differing view on a particular procedure, it is the role of the advisory group and the clinical governance framework to make sure that that is not disadvantaging the patient who, and we really must not forget it, is absolutely at the centre of all of this. I think it comes back to that, and comes back to that particular priority. That would be guiding our decisions as to whether or not to continue to allow that consultant to practice that procedure in one of our hospitals, because that decision is down to us, not down to the consultant.

316. You mentioned earlier on, actually, that you were broadly in favour of CHI; and, obviously, I, therefore, assume that you would be happy to come under the umbrella of CHI?

(Mr Auld) Yes.

317. If that is the case, would the independent sector be prepared to finance in full the element of CHI that would be needed?

(Mr Auld) Yes. This is a question that is often raised, Mr Chairman. I think our position, or my position, on this is very clear. I am sure my colleagues can speak for themselves. That element of the cost of the regulation that relates to the independent sector, in my view, should be borne by the independent sector, not borne by the state.

Chairman

318. Would you accept that as a principle, right across the board, for any form of regulation?

(Mr Auld) Yes, I would.

319. Is that a point of agreement between yourselves?

(Mr Pilgrim) Yes.

(Mr Ervine) Yes.

(Mr Hassell) Yes.

(Dr Vallance-Owen) Yes.

(Mr Auld) Can I, because I think it is important Mr Chairman, to place on record alongside that affirmation that there is, if you like, a condition that is an important influence on that. That is, provided first that the mechanism of charging is transparent, and, secondly, that the costs associated and built up over time are regularly, frequently and transparently

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Chairman Cont]

audited by an independent body, such as the Audit Commission. But, on that basis, I think it would be entirely appropriate and only fair that the sector should be standing its side of charges.

Dr Stoaite

320. I am very pleased with that answer, actually, and, I must say, you have made your position very clear on that, and certainly that has given me a lot of reassurance. Just one final point, Chairman, and that is, obviously, most of the large hospitals that perhaps your organisations deal with tend to be in the larger cities, in the larger conurbations, but outside those areas there are, of course, much more remote and smaller units. Do you think that CHI will be appropriate to regulate or oversee those activities, or do you think, for example, the Commissions for Care Standards might be more appropriate?

(Mr Hassell) If I may, on that. I think, as far as independent acute hospitals are concerned, yes, what we are suggesting, that CHI should regulate them, is appropriate for all acute hospitals. Certainly, the option of there being an extra region, if you like, for the Commissions for Care Standards, has been suggested. I think that would be a poor alternative, frankly, because I think a lot of the questioning which you have addressed to us, and, indeed, to previous sessions, expresses your concern and our concern about the present regulation, which is regulation of nursing homes with theatres added on; and I think the whole ethos of the Commissions for Care Standards will be similar, they will be concentrating, quite rightly, on the care situation and not on the acute hospital needs.

Dr Brand

321. I was very interested in your comments about the NICE guidelines. In the NHS, if someone stands outside the guidelines, they probably would have to justify themselves, because it is the institution that is as much responsible for the delivery of the service as the individual clinician. What is the relationship that you have with the patient and with the consultant, because there seems to be conflict at times, especially when we come to the complaints procedure later, who actually is in charge of what is happening?

(Dr Vallance-Owen) Certainly, in our hospitals, over the last few years, we have instituted both guidelines, in all our hospitals, but also care pathways, which are very much agreed between the consultant, the nursing staff, the physiotherapy staff, so that there is a clear sort of pathway, an integrated pathway, for a patient to travel through with each condition. And so, there, we are very much observing variances to those pathways and finding out where that variance came from, it might be the consultant, it might be the physio did something differently; so I think we are very much working down the road of trying to work and get more consistent approaches in our hospitals. And now, of course, we are also measuring the outcomes of what happens when those patients come out, we are systematically measuring the outcomes of patient care, using the SF36 form, three months post-treatment, and feeding that back

in as well. So I think we are very much working with consultants, in a multi-disciplinary way, to follow guidelines.

322. And what sort of hold do you have over the consultants, short of denying them admission rights?

(Dr Vallance-Owen) I think what we are doing with those care pathways, and, when we talk about measuring the variance and the outcomes, what we are encouraging the consultants to do is sit together in specialty groups and compare what they are each doing, the orthopaedic surgeons, to looking at their figures, sharing them, and having formal peer review. The problem I come back to, I am sorry to do it again, Chairman, is that we only know, of course, what the consultant is doing in our hospital, we do not know what the consultant is doing either in another private hospital or, more importantly, in probably the bulk of his, or her, practice, in the NHS. And, certainly, I believe that clinical audit should take on all of a consultant's practice, wherever that consultant is working, and that that data should actually be shared across both sectors, and we are very keen to do that and work with the NHS.

Chairman: This is an area we want to look at in some detail in a few moments, actually.

Julia Drown

323. I will come back then to questions on that a bit later. But can I just, first of all, pick up the issues over NICE covering both the NHS and the private sector. You recognised that it would take NICE a long time to get on to study all the procedures that were being done currently in the private sector, and that might be a particular concern, if there was a general feeling that regulation was not currently strong enough in the independent sector. But, even if we think NICE would get on to all these procedures, is there not a slightly different value judgement that NICE would have to take for a patient who is looking to the NHS for treatments, from one who is looking to the private sector for treatments? Because, is it not the case that some people go to the private sector because they do not like the NHS, they want to have something different, and particularly because they might have a different risk judgement from that which perhaps the general population have? So somebody might think "I really want to have this cosmetic procedure, I know there are huge risks involved, but actually it is important enough to me that I am prepared to take those risks." Now when NICE, as a body representing the general population, looked at those risks, they would say "There is no way we would approve this procedure", and yet there is something about the freedom of choice and freedom of individuals to take those risks, if they want to. How would you balance that, within one institution?

(Dr Vallance-Owen) I think that comes back to my point, through you, Chairman, about informing the patient; if there is an operation which the patient is prepared to pay for, and to take the risk, they need to know what that risk is, that is the crucial thing, and a consent form itself, I think, should have more information on it about particular types of things. Take the breast implant, for instance. I am sitting on a Department of Health Advisory Group, looking at

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Julia Drown Cont]

what the consent form should have on it, across all sectors, to warn patients about the risk that they may or may not be taking. And I think that is the crucial point, informed choice; and, hopefully, NICE, in making its judgement known, will not say just yes or no, it will explain its reasons for that, and that must be drawn upon, and we would very much want to encourage consultants to do that.

(*Mr Auld*) Can I also just add Chairman, that we still have not got away from what lies at the core of the procedures within the independent sector, that is a consultant having received a patient by means of a referral note from that patient's general practitioner. So while I take your comments and my colleague's comments absolutely on board, in the main it is within the envelope of the conventional approach of a patient who wishes treatment to be done going to his, or her, GP, receiving advice and information from that GP that is part of the informed choice. But it will start, and should properly start, with the general practitioner who, of course, is outwith, the end process of independent health care.

324. And at that first point of contact, so the GP has referred the person on to you, what sort of information do you give to a patient, at that first point of contact; do you give them a list of "These are the questions you must ask at your first consultation", or how do you make sure people do ask the right questions, currently?

(*Dr Vallance-Owen*) By and large, what happens is that the patient will not come near us until they have seen the consultant, the GP will refer to a consultant, and the consultant may have rooms in one of our hospitals, he may not; so it is really only when the consultant has decided that treatment or investigation is needed that the patient comes near us. And I think this is Charles's point, that we really have to work with consultants and the GP and make sure that that information is available to patients. We are doing a lot, as I know other companies are, in trying to work with patients in what we call informed decision-making, the word empower comes to mind, to empower patients, to give them more choice, so that they know what are the upsides and the downsides of certain procedures, and trying to encourage them to 'phone us, and, of course, NHS Direct is an example of that sort of availability of information, so that patients can ring up and find out, before perhaps they go down the road of treatment.

325. But at the moment we could not guarantee that, at that first point of contact, there is a list of questions for people to ask, at that first consultation?

(*Dr Vallance-Owen*) We just do not have access to that first point of contact, I think; that is the problem.

(*Mr Auld*) The consultant, of course, is obliged to secure consent. By and large I am quite confident on this, because we are talking about consultants, in the main, who are National Health Service consultants as well as operating in the independent sector. They are quite properly going through a routine that makes sure that the patient is aware of all of the implications of a procedure and what choices are available, including, I imagine, non-treatment.

326. I just want to go back to the point that Howard Stoaite raised earlier, about the possible different rates of intervention between NHS and the private sector. Do you publish regularly your rates of intervention, because I am sure if you did those people in the NHS who wanted then to compare theirs with yours would be willing to comment on them?

(*Dr Vallance-Owen*) We do not publish them, partly because it is almost, we are dealing with different geographical areas, different parts of the population, it is the old argument about league tables, you know, do they really enable you to tell the difference between different types of population, different types of surgeon, or not. But, I think, if we had the proper data and we were able to compare like with like, which is the crucial thing here, then I think we would be prepared to be transparent, and we ought to be.

327. How would you compare like with like?

(*Dr Vallance-Owen*) In terms of, if we had a common framework within which we were working and we knew what all of our consultants' practice was, as I said earlier, then one would know then what his, or her, intervention rate is in the NHS, as opposed to what it is in the private sector, but we are not able to pin that down at the moment.

328. But if you just published your side of things then I am sure that would inspire some other people in the NHS to compare theirs with what you had published?

(*Dr Vallance-Owen*) It may be something that we should think about.

(*Mr Pilgrim*) I think the important thing to consider here is that the vast majority of people operating in the private hospitals are the same consultants who are operating in the NHS, and those consultants who have a large private practice are typically the consultants who are providing an outstanding and excellent service in the NHS, because the GPs, who act as the gatekeepers, make the decisions regarding where referrals go. And so, when we are talking about referrals to a private hospital, the majority of those referrals, as we have said, the vast majority, are going through GPs, GPs are making informed decisions; if they are uncomfortable with the decisions that are being made in the discussions with consultants they do have considerable power, in terms of future referrals to that consultant, and they exercise those powers. But, as a general rule, the most successful consultants in the private sector are also providing excellent service in the NHS.

329. Just lastly, at this stage, you said in your evidence how you would like the form of regulation to move from looking at inputs to outcomes; can you give the Committee some examples of what should be measured, in terms of outcomes, in a new regulatory framework?

(*Dr Vallance-Owen*) There is a whole range, of course, through you, Chairman. Apart from the standard outcomes, which we all do measure, like deaths, reoperations, readmissions, and there are huge problems even defining death, sometimes, as to when it occurs, but that sort of outcome is crucial, and that we all are able to measure it, in terms of

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Julia Drown Cont]

statistical analysis. On the medical side, which is my area, I think we should be measuring functional outcome more, using the sort of tools that we are using, this 36 questionnaire form, which we are using, measures physical outcome and mental well-being, three months, a year, after treatment. And if we were all doing this, as we are now offering all our patients in our hospitals, and many of my colleagues in their hospitals, and that was happening in the NHS too, then you would have a really good database of outcome, which you would be able to build up over a course of time. But that is the medical side. Clearly, we also do a lot of work on outcome in terms of patient satisfaction. The NHS is doing a lot of survey work now on that. We have all, traditionally, measured patient satisfaction, all the time, as you might expect, and I think those figures also would be part of outcome, and you may want to talk more about that.

Chairman

330. Before we move on, just to clarify the point that you made about making available figures in respect of levels of intervention in particular circumstances; would that point that you made, the BUPA view, be shared by the other providers?

(Mr Pilgrim) Yes, provided the data was consistent and—

331. Consistent; you would all be happy with that kind of procedure?

(Mr Ervine) Yes, Chairman, and I think we are all advocating this whole practice data availability, it is a fundamental that goes through all sorts of things that we have talked about in our bits of evidence; we do not like this business where there are isolated pockets of things, of information.

Mr Walter

332. I would like to just look at this question of regulation from a different perspective. I am conscious that Dr Vallance-Owen's organisation also includes an insurance company, is probably better known as an insurance company, but the insurance companies are the people who are paying for the majority of certainly the elective surgery that is carried out in your acute hospitals, the majority of the treatments in your hospitals, and the major insurers produce lists of hospitals that they say you can go to, if necessary. Do these lists reflect any sort of inspection or quality control, or are they just evidence of a credit line being established or that they approve of your fee structure?

(Dr Vallance-Owen) If I can wave at the Committee the document which BUPA has just put out to all private hospitals and to all NHS Trusts which deal with private patients, which is the sort of document that they are asked to complete, and we are very happy to let you have copies of it, which is a long document, talking a lot about clinical quality standards, the Quality Framework I talked about earlier on, a lot of the things that are in that are reflected in here, customer service facts and a whole range of things that any hospital that we deal with has to be signed up to, and other insurers do the same thing. And we do inspect, we have the right to

descend on a hospital, and we do have multi-disciplinary teams with medical nursing and other people, who go in and inspect those hospitals; so it is, in a way, part of the self-regulation, which the sector does have at the moment, and it is quite right, I think, that we should know that where our members are being treated are up to proper quality standards. Of course, as you have heard, all private hospitals are also regulated by health authority inspection, which is particularly on premises and facilities, and that sort of thing.

333. Do you produce data, either publicly or privately, about comparative clinical outcomes amongst all the hospitals where you are paying for patients to be treated?

(Dr Vallance-Owen) The measurement of outcomes, for everywhere in the country, NHS and private, is at very early stages yet, Chairman, so at the moment the answer has to be no.

334. But, as you are paying, I wondered if you had got perhaps an advance there?

(Dr Vallance-Owen) The answer has to be, no, we are not able to produce that data at the moment, but we would very much like, as more measurement is done, over the course of time, to be able to use that more; but, again, it would be better if we could all be doing it, with the NHS as well.

Chairman

335. Can I just come back on that point, the point you made earlier, about the issue of looking at whether interventions are appropriate or not. Bearing in mind that you are an insurer, as well as a provider, and that you can look across the board at the independent sector as a whole, do you see any difference between the treatments that are provided for people who are insured and paid for through insurance, compared with those that are purchased directly by the patient, in relation to what actually is done for the patient, going on to the previous point we made about unnecessary interventions in certain circumstances?

(Dr Vallance-Owen) It is obviously an issue in which we are very interested, because we do not want to pay for inappropriate interventions, as an insurer, any more than patients want to be treated inappropriately. But, in fact, when it comes down to our data, again, we only have the data for our members, wherever they are treated, so—

336. What is your impression overall?

(Dr Vallance-Owen) We cannot make a comparison, Chairman, that is the problem, we do not know what the same consultant, we know what he has done for us over the last year but we have no idea what he has done in the NHS, we have no access to that data, and we do not know what he has done for other health insurers either. So this is part of the problem, the data, as I think David Ervine was saying, is sort of in different pools, in different places, and if we were able to share it we would know much more and be able to do much more with it.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued

[Chairman Cont]

337. So you think it would be worthwhile looking across the independent sector at the nature of the treatments offered to people who were insured and those who were not insured, perhaps; that might be useful?

(*Dr Vallance-Owen*) I think that would be quite interesting.

(*Mr Auld*) I would hasten to add, Chairman, so that it is absolutely, directly comparable with that which is picked up in the National Health Service, so that there is an absolute fit, so that there is no question of anyone wriggling around, from wherever, saying "Well, it's not directly comparable."

338. You take my point, I am making a distinction within the independent sector of the status of a patient insured or not insured, what check that offers to the patient in relation to treatment they receive?

(*Mr Hassell*) Could I comment, just to complete, hopefully, or to add to Mr Walter's question. Firstly, on the point of clinical governance, as Andrew said a moment ago, I think, to put it in perspective of timescale, the circular issued by the Department of Health, on 16 March of this year, indicated that this is the beginning of a ten-year programme to develop clinical governance, and I think that probably puts into context the whole of the discussion we are having this morning. We are at a very early stage of development, and it is important that it should be an 'across sectors' study. I think, if I can add, on the point of regulation, I am not speaking for the insurers, as Andrew was commenting a moment ago, but for the IHA, and that is because of the weaknesses of regulation. One of the things that we have put in place is a requirement on IHA hospital members to participate in an external, an independent, accreditation system, so that from 1 January next year all of our members must have in place, they must have achieved a pass through either the HQS system, one of the ISO accreditations, the Hospital Accreditation Programme, or one of the European Quality Frameworks⁴. So that is an additional requirement on our members. And I touched earlier on several other codes that we have put in place. So we have actually been adding to the quality requirements of our membership throughout the nineties, and I think that is an important point for you to take on board.

Mr Walter

339. Could I perhaps look at this from the other side, in terms of patients who are aggrieved, they have a complaint. The fact that their treatment was paid for by an insurance company, does that put them in a stronger position, in the way in which, if I bought some good with a credit card, if I am not getting satisfaction from the retailer I can ask the credit card company to sort it out for me; does the same thing apply in the independent health sector?

(*Mr Hassell*) I would hope that it would not make any difference at all. Clearly, if there is a funder, of whatever nature, involved, that may well give them extra leverage to deal with the situation, but that is not the principle that I would hope would apply.

Again, we have had a code of practice in place with hospitals since the beginning of the 1990s. Now we recognised, about a year or 18 months ago, that that was no longer up to speed with the modern consumer's expectations, and throughout last year we had a working party looking at revising that code of practice, and, indeed, my recollection is, when you had the consumer groups in a few weeks ago, the NCC were quite complimentary about the consultation process we had gone through there. And that will certainly place much more prescriptive requirements on hospitals, and indeed on doctors, to take part in a more formal complaints procedure. And not only that, we have suggested that one of the new features should be the ability, if a patient is dissatisfied with the way in which the complaint has been dealt with, that they would have the right to go to an independent review. And, furthermore, we have gone a stage further in our evidence in suggesting that the role of the Health Service Commissioner, the Ombudsman, should be extended to cover, again, all health care, and I think it is important to stress all health care, because we have touched earlier on some of the providers of health care that may not be registered at the moment, and I think it is important that the role of the Ombudsman is extended not just to cover our patients but, in fact, any patient who is receiving health care treatment in the UK.

340. Is there a fundamental problem, not a problem, as such, but a fundamental difference between a patient in the NHS and a patient in the private sector? In the NHS the patient is reasonably sure that there is a relationship between him and the National Health Service, in the form of a Trust, if he goes into hospital; in your case, the patient has a contractual relationship not only with you, as the hospital, but he has a separate contractual relationship with the consultant who is carrying out the treatment. And he may then have a third contractual relationship with the insurer who is picking up the bill. Does not that actually lead to some problems?

(*Mr Ervine*) Just to comment, Chairman. Yes, and that is really why we would like a comprehensive, enveloping complaints procedure that is mandatory, to pick up that particular point, to make sure that no one of those elements can opt out, in some way. I do not think it is a major feature at the moment, but we certainly do not want a situation where somebody can say "Well the patient might have a complaint but we don't want to deal with it."

(*Mr Hassell*) But that is the very purpose behind the much stronger code of practice that we have put in place. Certainly, one of the things that the IHA has done, together with the HCSA, and this has been running for a number of years for their members, is that we produced a number of postcards and posters which is encouraging, which is encouraging the consultant to make clear the relationships, his, or her, relationship with the patient, as, indeed, one of the publications of the Private Practice Forum, which came out a couple of years ago, has made absolutely clear, that the consultant and the hospitals must make clear their relationships with patients. And I think that the views of consumers have been

⁴EQMF Business Excellence Model.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Mr Walter Cont]

recognised throughout that code of practice, and, indeed, I think, with all the evidence that we have put into the Committee.

(*Mr Pilgrim*) If I might just make a comment. We, in IHA, recognised, probably a year, 18 months ago, that there was a need for change, that the complaints procedures in the private sector did not have some of the features that were available to patients in the NHS. But over the last year I think what we have seen is a sea change in attitudes amongst doctors, partly generated by the high profile problem cases, but we have seen a sea change in doctors now recognising that they cannot practise independently, if you like, whether within the independent sector or independently within the NHS, and have to be subject to far more institutional oversight. And I think our complaints procedures now reflect that, and the whole way that independent hospitals are managed reflects that.

Dr Brand

341. It has been interesting that we have been talking about quality standards, and the sort of buzz word is clinical governance, which we have had two or three times. There is an interesting paper by the Royal Colleges on 'Principles for a Private Medicine Clinical Quality Framework', a very snappy title; is that the sort of framework that you would all subscribe to?

(*Mr Auld*) We were part of it, Mr Chairman. We, the IHA, were one of a tripartite production. This comprised ourselves, in the independent sector, the insurers and the Academy of Royal Colleges, under whose aegis the forum was set up. So it is very much central, and if you spotted that it was virtually identical to our advocacy, that is absolutely right. It is what we are advocating.

342. Do you think there is something missing from it though, in the way of sort of external auditing and being a bit more open and transparent about reporting?

(*Dr Vallance-Owen*) This was done in the context of the sort of self-regulation which we try to do all the time, and a lot of it is in place already, and I think that we have said in our evidence that we want to be more transparent, we want to be able to share more data, and, as long as we can have that two-way flow, we would like to do that. And I think a lot of what is in that document, which we have all signed up to, is going to enable us to have that data and to collect it and to review it and to have proper peer review where you can do that.

343. And you would expect hospitals that you contract with, in your case, or hospitals that belong to your organisations, to subscribe to that and their clinical staff to subscribe to it, as a condition of belonging?

(*Mr Pilgrim*) Yes.

(*Mr Ervine*) Yes.

(*Mr Hassell*) They do, yes.

(*Mr Auld*) Yes.

(*Dr Vallance-Owen*) Yes, absolutely; we built it into our own quality standards, as I have said, but we have asked that it should apply for all independent hospitals, clinics, pay bed units as well, we want to try

to cover anybody who is looking after our patients. But, ideally, because it almost mirrors, [I do not know if you have seen this guidance which came out on the 16th]⁵, the Annex 2, at the back there, which talks about clinical governance; interestingly, our document is very, very similar, and that is another reason why we feel very comfortable about being able to have the common approach.

Dr Stoate

344. I think, Mr Auld, briefly, you talked earlier on about Medical Advisory Committees having, I think it was, a role in policing, to ensure that good standards of admitting doctors were maintained; but we have received a memorandum from the Hospital Consultants and Specialists Association which shows some concerns really about whether MACs really actually have got enough power, and particularly to quote from their document, they say: "It places a huge burden on the MAC chairman, who does not have the power to institute proper auditing or monitoring systems, and who sometimes is not even medically qualified." Now how is someone in that position going to have control over the quality of admitting doctors, to ensure they really are up to the scratch that we want them to be?

(*Mr Auld*) I have almost paused at the point at which you said that there is an assertion that an MAC chairman would not be medically qualified.

345. It was not my assertion, it was the Association's.

(*Mr Auld*) I will look to my colleagues, but I can say, quite positively, in the case of all of my hospitals, not one. Any, gentlemen?

(*Mr Pilgrim*) No.

(*Mr Ervine*) No.

(*Mr Hassell*) No.

(*Dr Vallance-Owen*) No.

(*Mr Auld*) I think we could probably say that if it does exist, it will certainly be very rare. Turning, however, to the other aspects of your question. It is certainly true that the Chairman of a Medical Advisory Committee is heading just that, an advisory committee. Therefore, at face value, the powers would be fairly limited. However, I would ask the Committee to dwell on the situation of the hospital, when faced, through the Medical Advisory Committee, with either a practice, an arrangement, a system, or piece of administration, that is unsatisfactory and is not in the interests of the patient, or indeed of the consultant. If that hospital refuses to make the appropriate change, then remedy is speedily available to not only all members of the Medical Advisory Committee but also to all the other doctors and consultants who visit that hospital. Almost inevitably, there is a competitor just down the road, giving the doctors the freedom of choice to be able to say "Fine, I am not going to bring my patient to your hospital if you are not going to get up to scratch" on such-and-such a thing, whether staff up accordingly, or whatever. I have to say that my experience, within my Group, and anecdotally elsewhere, is that occasions like this are very, very

⁵Clinical Governance—Quality in the new NHS HSC 1999/065.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Dr Stoaite Cont]

rare. I cannot actually remember one, to be honest. So I am saying that the power not only exists but it is very real. Advisory Committees' advice is rarely, only very rarely, overlooked.

346. I am not worried so much about that, I am worried about whether the advice can, in fact, be good enough, because some hospitals, the larger hospitals, may have literally hundreds of consultants with admitting or visiting rights; now a part-time chairman of an MAC is going to find it pretty difficult to really get a feel for the clinical quality of what might be several dozen, or even hundreds, of his colleagues?

(Mr Auld) I think the onset of the clinical governance frameworks that we are setting up is such that there is no doubt that the Medical Advisory Committees are now going to be looking at, already are, and in future even more, information within the hospital being collected on a specified set of parameters. It will be an obligation upon the staff of the hospital, and indeed upon the clinically responsible person within the hospital, to be scrutinising and to have recorded that such records have been scrutinised and commented upon. So what is now happening is that machinery is now being put in place and resource being made available to Medical Advisory Committees in, if you like, serving up more information for them to review the performance of the hospital, more than is there already.

347. Those are admirable sentiments, I think that is entirely the right approach, but I am still slightly concerned about whether it is physically possible for a chair of an MAC really to have that much of a policing role on a weekly or monthly basis, I do not see how it can be done that way.

(Mr Pilgrim) If I can come in. I think one of the strengths of the MAC is, effectively, the college system which exists, where you have representatives from each of the major specialties working together on the Medical Advisory Committee, so if you have a group of orthopaedic surgeons there will be one representative on the MAC, and so although the chairman may not have intimate knowledge of what is going on in orthopaedics the representative on the MAC from that specialty certainly will have, and he will have a responsibility, through being part of the MAC, for making sure that issues are brought to the MAC's attention.

348. But is there not still the worry of collusion, because, obviously, he is working with his peer group and his colleagues, is there not the possibility that they might want to sweep things under the carpet, and we have seen some high profile cases where there have been real problems, of late, they might be isolated but they are problems that, clearly, were overlooked, and whether they were deliberately overlooked or whether they were just not seen, they nevertheless represented a real problem for the public?

(Mr Pilgrim) I think we have seen this change going on, and it has accelerated very much in the last year or so, and I think that the doctors, more and more, recognise that that sort of behaviour which may have influenced some of the high profile cases just will not be acceptable in the future. And also

providing information, I think, is important; withering information provided to doctors on comparative performance will help to improve decision-making.

(Dr Vallance-Owen) One of the things, Chairman, that we have just started to do, in support of consultants on MACs, if there is a problem in terms of them assessing a colleague, and one of the things we have just done is worked with the Royal College of Surgeons and an NHS Trust, it is a tripartite thing, and we have sought the advice of two consultants from independent areas in one of these rapid response team exercises, where two consultants are nominated by the Royal College of Surgeons, they are prepared to come along and speak to a consultant over whom there is a question-mark and to make an assessment. And I think that is one of the things that we hope the Commission is going to be encouraging, it is going to be working with regional offices and the Royal Colleges as well, and encouraging, I think that sort of approach. So that does take it out of the MAC, if there is any question, which is a point you raised, of whether they can be independent or not, I think then you can do that, and we should be able to draw upon College expertise for that sort of advice.

349. I note, from the same report that we have been given, that BUPA, in fact, have amended the rule book recently to stipulate that each hospital's MAC, the chairman, in fact, of each hospital's MAC, is to be held responsible for monitoring the quality of doctors to whom the Committee grants visiting rights. Is that really realistic?

(Dr Vallance-Owen) I think it is, through you, Chairman, I think it is realistic. I think all the lessons, and we have learned many lessons over the last two or three years, it is that we have to have much better peer review within the profession, and I think MACs very much recognise their responsibility. If one of their number does carry on as a poor performer and is found out, that damages not only the patients, which is the prime responsibility, but everybody in that area. It is in everybody's interests to tackle poor-performing consultants, and I think Sir Donald Irvine, the President of the General Medical Council, has also made it clear recently that he believes the chairman of an MAC is in a similar position, in terms of professional accountability, to a medical director of a Trust. The MAC chairman does not have an executive responsibility but he has a professional responsibility to try to observe and to monitor what is going on with his colleagues, as Alan has said, and I think they take that responsibility very seriously.

350. I am sure they do, but I have still got one more point I would like to raise with you, and that is, you mentioned that they can deal with a failing consultant, or the consultant who is obviously providing a very bad service, clearly there is a third group who are brilliant and wonderful and nobody worries about because we all know they are good, but nevertheless there could be a grey area in the middle of people who perhaps need more monitoring, they are not bad, they are not disastrous, they are not causing great high profile problems, but, nevertheless, may not be to the standards you want. Now how can a chairman of an MAC really monitor on a regular basis whether they are keeping up with their clinical reading, whether they are taking their

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Dr Stoate Cont]

post-graduate education seriously, whether they are attending conferences to keep up to date, particularly with new techniques and surgery coming on stream all the time, and how can a chairman of an MAC really make sure that the consultant is not just adequate, not just not dangerous, but positively good enough?

(*Dr Vallance-Owen*) I know Charles wants to come in on this, but let me just say that they are obviously supported, the chairmen and the MACs, by the chief executive, or the general manager, of the hospital, and a lot of that sort of monitoring is done within the hospital by the support that they have on the staff, so it is not as if they are entirely alone in having to do this, and, I think, the more information that we are collecting, the more we monitor and analyse for them.

(*Mr Auld*) The point I was going to make, Mr Chairman, was of discussions that we have had recently with the GMC. The Committee may be aware that the GMC has just adopted the process of validation, or revalidation, of doctors on a regular basis. We have been asked what our reaction, as the Independent Healthcare Association, would be to being involved in that. We have said yes, that not to recognise that 20 per cent of elective surgery of these self-same doctors being done in the independent sector and not to have that as part of the validation process would seem to us to be illogical. Fortunately it does look as if the Council agrees with that. So, further to your point, it does look now as if the performance of the consultants within the independent sector will be part of the validation process. We do not yet know how that information is going to be collected but, rest assured, (again on a comparable basis) we will be supplying the information. I have to say, speaking now about my own Group, Mr Chairman, that the consultants are really very pleased about this. I would not want the Committee to feel that we are trying to drag consultants kicking and screaming into this at all. On a widespread basis, this is meeting with total approval. The need for change, the need for transparency and the need for better accountability for action, has consultant support and it is widespread.

Julia Drown

351. Just a couple of points on this area. Are you then saying that 100 per cent of your consultants will be taking part in peer review and in clinical audit, are you saying that if a consultant is not willing to do that then you will not let them practise in your hospitals?

(*Mr Auld*) Chairman, part of the conditions of admitting privileges will be to engage in activity of that sort, clinical audit, and clinical governance. Consultants who wish to practise in private hospitals, certainly in our case, sign up to a series of conditions. Their admitting privileges are, in fact, attached as an Appendix to our evidence. The conditions there would show that there are obligations laid upon the doctor to conform to activity such as that within the hospital, as a condition of practice.

352. For how many years has this been happening?

(*Mr Auld*) In our case, it has been happening for quite some time. Clinical governance and outcome information, of course, is something that is as in the National Health Service, really quite new. It is a new practice. What has obviously been around for many years is the Medical Advisory Committees' routine scrutiny of untoward incidents that occur within the space of time intervening between the last meeting and the next one, a month, or a month and a half, and, routinely, a schedule of untoward incidents would be presented to the Committee for its consideration. If patterns are emerging then they will be investigated, and routinely are.

(*Dr Vallance-Owen*) And it is built into the Quality Framework too, that you have had presented to you, very clearly that that should happen.

353. And the other thing is, would you recognise that there is a difference in the practice within the private sector from the NHS, in that in the NHS you tend to have a bigger team of consultants working in any particular specialty, together with more junior doctors and nurses? So, in that way, there is an extra safeguard for people in the NHS, because there are junior doctors, in particular, who are seeing the different practice of different consultants on a regular basis, so there is another avenue there for them to raise alarm bells, in a way that, in the private sector, if you have got doctors just coming in, perhaps just booking one session once a week, and they are floating out again, there is not that regular contact and regular team work that enables a number of people within that team to raise alarm bells, if one person's practice is very different from the others. And if you do recognise that, would you then follow that through, to say that that means there needs to be some extra, additional regulation within the private sector to counterbalance that?

(*Dr Vallance-Owen*) I think consultants take their responsibilities *vis-à-vis* their patients in our hospitals extremely, extremely, seriously and they are very, very careful to make sure that they are properly cared for; they would not bring them into our hospitals, because they are responsible for them, if they were not happy with the standards of support that are there. I think one of the things I talked about was care pathways, earlier on, which is very much a multi-disciplinary approach of support around guidelines and trying to get consistent paths of treatment, and we monitor very carefully if a patient is falling away from that. So I think that is the principal point that one makes in a follow-up to that question.

Audrey Wise

354. Who should ensure that surgical procedures being carried out in the independent sector are within the qualifications and accreditations of the doctors involved?

(*Dr Vallance-Owen*) All of us, I think, Mr Chairman. I think insurers have a role to make sure that before they recognise a consultant they should make sure a doctor has been put through the proper hoops and is only practising within the specialty for which he, or she, is on the specialist register that I talked about earlier on. Certainly, hospitals, in giving admitting rights to consultants on the advice of

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Audrey Wise Cont]

Medical Advisory Committees, are very careful to check the credentials, that they are a consultant, they are a specialist in that field, and that they should only work in that field. And, in addition, for instance, if there are sort of extra areas, like keyhole surgery, minimal invasive surgery, I think that we all now also check that sort of thing, that they have got proper experience, that they have got the right number of operations, and that sort of thing. It is the responsibility of all of us.

(Mr Auld) Could I, Mr Chairman, refer to our Conditions for Admitting Privileges in a Private Hospital. I think it is within the evidence as an Appendix. Very briefly, under the heading New Techniques, the relevant text and I am sure my text is not very different from the text of anyone else here. 'The introduction of a new technique or procedure must have the support of the Medical Advisory Committee, which may take specialist advice, including but not limited to that of the Safety Efficacy Register. The practitioner must be able to produce documentary evidence that the new procedure or technique is supported by current professional guidance, including that issued by the appropriate Royal College, and that he is appropriately trained and accredited in the undertaking of that procedure. And, lastly, the practitioner must also ensure the suitability and experience of the hospital's staffing in related techniques and the availability of support facilities with regard to patient safety.'

355. Right; and can I pursue that a little bit in relation particularly to children. We have had evidence from the Royal College of Paediatrics and Child Health that they are concerned about the standards of care provided to children admitted as private patients under the care of adult surgeons, anaesthetists and physicians; clearly, they would be adult, but I think the College means qualified with special reference to adults. And the Royal College says: "These concerns relate mostly to admission for relatively minor surgery, for example, tonsillectomy, insertion of grommets, correction of squint, circumcision and minor orthopaedic procedures." Now they are described as minor, but, of course, any surgery on a child is important, any surgery on anybody is important, and things can go wrong, and they can be inappropriately done, and all the other concerns that have come out. What steps do you take to make sure that children being looked after are actually attended to by appropriately qualified doctors and, in this case, nurses, as well?

(Dr Vallance-Owen) I will start, maybe, but I think we are very tough. Obviously, our registration arrangements, in the first place, from our health authorities, say what sort of age group we can look after, and you have to have special arrangements. I do not think any of us would want a child, or any patient, to be treated in one of our facilities where we were not sure that there was the back-up support, that the doctor looking after them had proper advanced life-saving certificate support for children, and all those things. I think we, all of us, attend to those issues very, very carefully, and I think, for practically all of us, none of us will treat children under the age of two, certainly, I think, practically all those children are looked after in specialist centres.

(Mr Hassell) I think the only thing I would add, if I may, which Andrew touched on, is that, under the guidelines issued by what was then the National Association of Health Authorities and Trusts, guidelines they issue for registration inspection officers, if I recall, there is more space, more pages, devoted to covering children's needs and the responsibilities of the registration authorities and their liaison and requesting standards of the hospitals, I think there is more space covering this particular point than any other subject. So I think that illustrates how everybody takes the issue of children's treatment extremely seriously.

356. Yes; taking it seriously is a very wide term. When this Committee looked at children's health a while ago, a comparatively short while ago, we found that, in fact, there was considerable difficulty in ensuring that children were attended to by appropriately qualified people, even in the NHS. Now the Royal College here is expressing its concern that, in fact, children are being treated by people who normally work on adults; there are considerable differences between the needs of children and adults, in many ways, physiological through to psychological and social. So are you saying that the Royal College is wrong in its concerns, and that you do actually ensure that they are tended to by doctors who are specialising in children?

(Mr Auld) Yes. I can speak with some confidence on the matter, but I will be interested to look specifically at the evidence, when that becomes available, Mr Chairman. I would say that we always ensure that there is available a registered sick children's nurse; and a mother and child room, it is extremely important, where there are such procedures to be carried out, that there is a facility for the mother to be with her child, pre- and post-operatively. We look very carefully at limiting, if appropriate, the acuity of the procedure, and that would be done in conjunction with the Medical Advisory Committee and, essentially, then advising the consultants, and if need be GPs, if there had been a referral route there, upon review, and saying "We would go no further than this level of acuity on these procedures when related to children." And I would also say that there are quite a few things, when one is talking about the obstetric side, that we would stay well away from, on the basis that that would be better handled elsewhere. So I think what I register with the Committee is that we, certainly, and I am sure my colleagues as well, approach the area of the treatment of children very gingerly, very carefully. As I say, I would be alarmed and would be prone to action, on the basis of having heard these remarks, and I look forward to seeing the evidence and taking it forward, if need be.

(Dr Vallance-Owen) We do have some guidelines within our hospitals about the care of children, which we would be happy to submit to you after this meeting, so that you can see the way we take that forward.

357. You used the word availability of a sick children's nurse; does that mean that the children would be actually cared for by a trained children's nurse, would there always be a trained children's nurse on duty?

(Mr Hassell) Yes.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Audrey Wise Cont]

(Mr Auld) It is a requirement of registration, Mr Chairman, that that is the case.

358. The Royal College also says that they are concerned about failure to provide policies and protocols specific to the needs of children, and equipment appropriate to their size and age. Are they wrong again?

(Dr Vallance-Owen) We have our guidelines, as I said, so we certainly have them, I think probably all of us cover this, in one way or another, in our hospitals; we will certainly send you ours.

359. Yes, I think it would be useful to have these things sent to us; and are they actually carried out?

(Dr Vallance-Owen) Yes.

Audrey Wise: And they also say that they are concerned about poor pain management and lack of paediatric pharmacy support, and also the psychosocial aspects of the care of children are frequently ignored. It is a pretty comprehensive complaint. It is surprising really, if the Royal College is putting that in evidence to the Select Committee of the House of Commons without having anything to go on.

Chairman

360. I wonder if we could possibly let you have a copy of this evidence to look at, because I think it is only fair for you to see what is being said, and obviously you have indicated your willingness to send to us specific information relating to children. Is that agreeable, from your point of view?

(Dr Vallance-Owen) Yes.

(Mr Ervine) Yes.

(Mr Pilgrim) Yes.

(Mr Hassell) Yes.

(Mr Auld) Yes, absolutely.

Audrey Wise

361. Then can I move on to ask you how you think the range of surgery and cover for a typical 40-50 bed independent hospital would best be regulated?

(Mr Pilgrim) I think, as far as the regulation is concerned, the most important aspect of it is the admitting privileges. I think the Medical Advisory Committee, when granting admitting privileges, must not only recognise the capabilities and the experience of the individual applying for admitting privileges, but must also recognise, and limit, if necessary, the types of procedures that that individual can perform because of the nature and the services available in individual hospitals. I would have to say that most of the hospitals represented here today would be able to cover the broadest range of acute elective surgery, each of the groups has some hospitals which can do more complex surgery, but most of the hospitals represented here today and represented by IHA can cope with most elective surgery. But we would see the admitting privileges being the key thing, and the MACs' role in that; and, ultimately, the chief executives of the groups have responsibility to make sure that that is being followed through. Ultimately, the admitting privileges are granted by the organisation, not by the Medical Advisory Committee.

362. Of course, there is a lot of concern, is there not, that surgeons should do sufficient of a particular procedure, it should not just be an occasional one-off?

(Dr Vallance-Owen) Yes.

363. And, of course, in smaller hospitals, that can be quite a problem, even in big hospitals, for more complex things; is this what you mean when you talk about limiting the range?

(Mr Pilgrim) Absolutely. We would look at the number of procedures that an individual consultant is performing, both in the NHS and in the independent sector, and would take that into consideration. I think the increase in the information will help that process, I have to say, and that is one of the important aspects of the information systems, that we are all improving all the time, that it will improve the quality of information regarding those procedures which are done very rarely.

364. A doctor suspended from working in the NHS, even because of concerns about his, or her, clinical competence, can then be found continuing to practise in the independent sector; why do you allow that?

(Dr Vallance-Owen) I would be very worried if that was the case, Chairman. I think, all of us take very seriously any information we may receive from the NHS about suspension of a consultant. We do have a real problem, in that an 'alert' notice is sometimes issued by the NHS, and then when we ring the Trust and we say "What is the problem, is there an issue of patient safety here?", because we will obviously want to tackle that consultant, they sometimes say to us "Well, it's confidential", or "It's under investigation", or "For legal reasons, we can't tell you." And it is an issue we are raising with Ministers at the moment, because it comes back to the data flow really, we really do need to know if there is an issue of patient safety, we will always inform our colleagues in other hospitals and the Trust, and we really need to have that interchange of information; but as soon as we know that that there is an issue of patient safety then, I think, all of us act immediately, and the same on the insurance side. So I am pretty confident of that.

365. It has been raised with us that one of the problems about independent hospitals can be not so much the surgeon who is doing the operation but the back-up, and the out-of-hours back-up, in particular, and that the resident medical officer may really not be competent to deal with the range of problems left in his, or her, hands when the consultant has gone back to do, as you say, the rest of their work in the NHS. How would you answer that complaint?

(Mr Auld) If I may, Mr Chairman, I would answer it in several ways. First of all the qualifications of the resident medical officer. He or she must already be in receipt of an MBCHB, an MBBS, or equivalent academic and practical qualification, and these are checked. Secondly, in receipt of advanced life-saving techniques certification, which is now being checked by us direct with the association responsible for mounting and monitoring the resuscitation technique training. We will now, independently, verify that a person does indeed have that certificate.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Audrey Wise Cont]

Thirdly, to remind the Committee that the patient who is in our hospital, under the supervision of an RMO in the evening, or when the consultant and the consultant anaesthetist are not present, is still the responsibility of the consultant, and the consultant anaesthetist, post-operatively. A condition of privilege of use of hospital is that his, or her, patient can be put in contact with him at all times while in our hospital. So that there must always be contact maintained or available, and that is clearly understood by consultants. If, in the judgement of the resident medical officer, there is a need for the consultant to make a visit the consultant is then contacted and the hospital has the contact numbers for the consultant and the anaesthetist. If the consultant, on a rare occasion, has to be absent and is not contactable, he will make arrangements and we will know of the arrangements when he is not available. He will have made alternative arrangements, typically with a colleague, whom he will have briefed.

366. Yes, but there will be lots of times when he is actually operating. I can understand what you are saying applying if he is on holiday, or something, but if he is actually operating, and you could put another patient in jeopardy in order to attend your patient, it could be very awkward. Are you telling me that they will always, always, have arranged a deputy, that the deputy will be sufficiently within range to be able to attend in a short space of time, and all of that, for every patient, all the time: it sounds quite an undertaking?

(Mr Auld) Yes, I believe that the evidence, Mr Chairman, I think the historical evidence is that these arrangements work very well indeed. One of the reasons, I think, that they work well is always to remember that, in the first place, the independent hospital is typically restricted to a range of elective surgery, which is typically, again, not acutely life-threatening at that moment in time. It is not an emergency procedure. We are not embarking on some of the very sophisticated, highly intensive procedures which an NHS district general hospital would be undertaking. Secondly, if there was any identifiable risk that a patient could be prone to an escalation of that nature, again, in the vast majority of cases, the consultant's own judgement will have predisposed him to say "I will not bring this patient to an independent hospital, because, by dint of age, by dint of medical history, I think this patient will be better in my care within the National Health Service." So one is certainly whittling down to a very small number of cases those that are at risk, by a process of risk reduction. I would also have to say that I cannot, and I am not being asked to, say that it has worked in 100 per cent of cases. Sadly, it has not, and I would not be able to say that that was the case. But I would assure the Committee that the evidence would be that it does work, and the best evidence is that if it did not I do not believe that the independent sector hospitals would be as busy as they are. I believe that the consultants, who are in the main National Health Service trained and practising and with whose judgement everyone, I believe, is very happy in the National Health Service, are the same men and women who are employing the same clinical

judgement when applied to their private practice patients. I do not believe, in the main, that they apply different judgements.

Mr Walter: I am not sure whether I am necessarily reassured by that answer, in comparing the private sector with the NHS. Somebody is referred by their GP to a consultant in the NHS and they turn up at the clinic, they may well see the consultant, they may well see a specialist registrar, when they are admitted they will come under that whole team, that firm, of the consultant, specialist registrar, senior house officer, house officer, etc. The whole time they are in the NHS hospital that team will be looking after them, even in the wee small hours, there will be at least a house officer or a senior house officer who has been involved with that patient from the time they were admitted, who knows what is going on, knows the complete history. My concern is that, in the independent sector, the point of contact is the consultant, who comes along and performs the piece of elective surgery and goes away again. Now we all know the history of this, that he may well be performing that in one of his periods when he is not working for the NHS, or, as I have heard some patients say, "Wasn't it marvellous, he did this at 7.30 in the morning", well, of course, he did it before he did his job in the NHS. But he then goes away again; and then you are left with the RMO. I was a little bit concerned, in your answer just there about the RMO, saying that he is MBBS, and life-support techniques; that could actually be a house officer. Do you not feel that you should be providing a more comprehensive service, in terms of the cover which you provide, whether that is consultant-led, or whether that is led by you, as independent hospitals, I am not sure, that is a commercial judgement that you have to make; but, very often, the concerns that are expressed to me, and the ones we hear about, the headline ones, are because the back-up was not there? Now I am not saying that in every case in the NHS the back-up would have been there, or that the outcome would have been any different, but it is an area where you lay yourselves open to criticism, and I just wondered if you wanted to expand on really the qualifications of the people who are providing that kind of back-up care?

Chairman

367. Could I reinforce this point, because it has come over very, very clearly in the last evidence session that we had here, and I think you may have heard, some of you, or were represented here, so you know the kind of cases that we were hearing about, that concerned all of us very much?

(Mr Pilgrim) Clearly, there are some extremely distressing cases, and we are all upset about those distressing cases. I think the issue really is that health care is being provided in a number of different settings now, an increasing number of different settings, and from all of those settings there is an element of risk associated with it; in the past, everything was carried out at a district general hospital, with everything present. But, increasingly, care is now being provided in community hospitals, it is being provided in people's homes, and all the time there has to be an evaluation of the risks

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Chairman Cont]

associated with that. I think the evidence would suggest that we have got the level of the cover right, in independent sector hospitals, in that the number of patients where there is a problem which needs readmission to the NHS is a very low percentage and that we have actually got that risk evaluation about right. Now, clearly, in the instances where it is not right it is a terrible tragedy, but any health care, in any of the new settings, has a risk associated with it, GPs are increasingly doing things in their surgeries, those have more risk than if they were done in a district general hospital, and I do not think there is any clear evidence to suggest that the risk element has got out of balance in the private sector.

Chairman: Peter Brand is frowning here, I have got to bring him in.

Dr Brand

368. Yes, thank you. I am slightly worried about this. I think that doing a minor procedure, not minor surgery, under local anaesthetic is not comparable with minor surgery with general anaesthetic; there is no such thing as minor surgery, there are minor surgeons, I was always told, and there is a risk once you employ general anaesthetics, much more so than if you are working on the local, and you have got to accept that, and it is a risk management. And I am not convinced that the present arrangement, where the responsibility for managing this risk is with a consultant who cannot be present, and who cannot guarantee to be there within ten minutes, or an hour, or two hours, sometimes, if they are in a specialty where they are stuck in theatres for half a day, whether you have got that risk management right; and there may be very few cases but they are nearly all avoidable cases where this goes wrong?

(Dr Vallance-Owen) Chairman, can I come in with one or two points. I think you are absolutely right to raise the concern, but I think that, as I said earlier on, we treat 850,000 of these patients in the sector every year, and we are very, very careful about risk management, and, as I think I also said, I think consultants just would not be leaving their patients in the care of the staff in private hospitals if they felt that there was a risk to them. One of the things we have not covered is, as well as the RMO, and they are all post-registration doctors, there is no question of them being house officers, just to satisfy that one point.

Dr Brand: Fine; good.

Mr Walter

369. So they could be senior house officers?

(Dr Vallance-Owen) Yes. But one of the points is that, as well as themselves being properly up to date and properly trained, with advanced life-saving support, nursing staff and the hospital staff these days are much, much, more able, in multi-disciplinary teams, to work. And it may seem strange, coming from a doctor, but they are superb in the support that they provide in resuscitation, and things have changed enormously over the last few years, in the sort of training and the back-up that the nursing staff provide, and our nurses who are on duty, we always have nurses able to provide that

back-up. I think, another point on staffing is that, at the end of the day, we are inspected by health authorities, who provide the registration, and one of the things they do look at is their satisfaction with staffing arrangements for this sort of thing, and they lay down some basic sort of rules on that. And, finally, if the operations are more complex, we do staff up; obviously, if we have an ITU in the hospital and we have got a more ill patient, we will have extra staff on. In our cardiac hospitals, for instance, which are having coronary artery by-pass graft, open heart surgery, of course we have more senior staff available to treat that sort of patient. So I think we respond, we risk manage, according to the risk.

Chairman

370. Before we go on to complaints, which Mr Lewis picked up earlier on, could I just come back to the point Mrs Wise made about where an NHS doctor is suspended, or not just suspensions but where there are concerns about the practice of a doctor. Because this Committee, as well as looking at this as an issue within this inquiry, will be looking at the issue again in another, wider inquiry, primarily geared to the NHS, in due course, later this year. Could you say a little bit more about the way in which, where there are concerns about the practice of a doctor in the NHS, who is a part-time consultant working within one of your establishments, you would handle such a matter? And I appreciate this is a very delicate area, because, obviously, the doctor has got certain rights. But I have come across in my area a situation, I do not want to go into the detail of it, but it did cause me some concern, that it was put to me that a doctor who had been suspended in the NHS, who had an involvement in private practice, could, I am not saying did but could, have carried on in circumstances where serious questions were being raised about this particular person's competence. Will you say a bit more about how things work at the present time, and how you would favour changes coming in to give greater checks on the patients' interests? And, looking at it the other way round, looking at the problems in the NHS impacting upon the private sector, looking at it the other way round, where you have said yourselves, you sometimes pick up problems with a consultant who is working in the NHS, from what you see of their practice in the private sector, how would you deal with that situation, and how would the NHS pick up the problems that you are identifying?

(Dr Vallance-Owen) Can I lead off, Chairman, on this one, because I think the doctor you talked about is one that I am aware of, where I think there was a question about that particular surgeon's ability to operate, to actually practise the art of operation, and it was that part of his work which was suspended within the NHS. As soon as we heard about that, we also suspended his surgical operating rights; there has never been, and we may not be talking about the same person, but—

371. We may or may not be, it would be wrong to assume too much. How would you pick that up; as soon as you picked it up, were you informed, or how would it happen?

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Chairman Cont]

(*Dr Vallance-Owen*) Let me just walk through; sadly, it is often more on the grapevine, I think, to be fair. Our consultants, working in our hospitals, also work in NHS Trusts and they hear about these things and they let us know; and grapevines, as you know, can be very effective. But often, though, it is fair to say that the Trust will inform local private hospitals, and they will say this is happening and local private hospitals will act accordingly, immediately, if there is any issue about patient safety; sometimes, though, that does not happen, and it is very hard to verify what has actually happened. It is easier when a consultant has been suspended formally, but not infrequently a consultant is put on what is called 'garden leave', and therefore the Trust is able to say "Well, actually, there hasn't been a suspension" and they will not say to you what the issue is. Now that does pose us a problem, and I have put up three cases where this has happened with us to both the GMC and Ministers, because we believe that there is a duty of care by at least the medical director in the Trust, as we believe there is a duty of care on our side, of an MAC chairman, to inform any hospital, doctor to doctor, at the very least, in the local area, if there is a question about a doctor's safety with his patients; and so that does not happen, at the moment, always.

372. Say you have got a situation where, you term it 'garden leave', which is an interesting term I have not come across, but I think I understand what you mean, say that a part-time consultant, in the NHS, was sent on leave, on the basis that the Trust at the time did not have sufficient evidence to pursue the matter further, where it was a general agreement that it would be easier if he, or she, was not in the Service. How, in those circumstances, would you act, when the person had not been suspended but there were serious doubts, and that person, working within your hospital, obviously, has certain rights, himself, or herself, if nothing has been proved either way?

(*Dr Vallance-Owen*) If there were hints, and sometimes it is that, but nothing has happened, I think, it is extremely difficult; we, all of us, have internal, professional review procedures, run by the Medical Advisory Committee, which can review a consultant, but I think if you have not the data, the information, from the Trust what you have to do is maybe consider this idea of getting in the Royal College, the relevant Royal College, and asking them to send a couple of completely independent consultants in the same specialty to advise and assess the consultant on that basis.

(*Mr Auld*) I was just going to deal with the specifics of your question and the particular nature of the uncertainty. My experience is that where a consultant has been suspended from his NHS post, pending investigation, and that has come to the attention of the hospital director, the hospital director would consult with his MAC chairman. He would ask "What do you know?". The MAC chairman may well say "Well, not very much, it's all a bit mystifying", in which case the hospital director would then invite that consultant to come in, and would say "Look, I've heard that you have been suspended; are you prepared to talk to me about it, or do you feel that that would be difficult? In the event that that is difficult, I think it would be appropriate if you suspended further activity within

the hospital, certainly in terms of operating, although, clearly, you would have a duty to continue to see existing patients post-operatively." Obviously that would not involve further intervention, that would just be the continuing care of the existing patients. In my experience, though this is very rare, that is the way that that is handled. It is seen to be fair, it is not prejudicing the consultant's rights in the matter, but, equally, it is protecting the reputation of the hospital, and indeed the other consultants who bring patients to the hospital. Ultimately, it is in the patients' interest. If, for any reason, the consultant says "No, I refuse to suspend temporarily, pending NHS investigation", the hospital director has got the right, and that would usually be exercised in consultation with his MAC chairman, but he does have the right to say "Well, in which case, I am now not asking you, I am withdrawing, albeit temporarily, your privileges, with the exception of the ongoing care of patients of yours who are in the hospital at the moment, but I regret you cannot bring any further patients to the hospital, for the time being." And that is laid down.

(*Mr Pilgrim*) I would like to point out, this is not just a one-way street, we have a situation in our Group where we have removed admitting privileges from a consultant who is actually still practising in the NHS.

373. That was the second part of my question; what are the NHS doing about it?

(*Mr Pilgrim*) The NHS are well aware of all the facts and they are investigating those facts, in conjunction with the GMC. But, from our point of view, we used our power to remove the admitting privileges from that individual; and, indeed, communicated with colleagues along this table, so that, if you like, the knowledge of what had happened was known within the industry. And we think that is an appropriate way the grapevine should work.

374. All this is a general area where you recognise there are serious problems, on both sides of the state/private divide?

(*Mr Pilgrim*) Yes.

(*Mr Ervine*) Yes.

(*Mr Hassell*) Yes.

(*Mr Auld*) Yes.

(*Dr Vallance-Owen*) Yes.

Dr Brand: But you would not want to see a situation where suspension by the NHS would automatically mean that you would have to suspend; because people get suspended for all sorts of reasons, which may not be clinical?

Chairman

375. Exactly; is that the case?

(*Dr Vallance-Owen*) The independent sector has got to be for both consultants and patients.

Chairman: Can I come on to that, because a consultant in the NHS may be suspended for some criminal offence, or be accused of something.

Dr Brand: It might be for being rude to his colleagues, I think it is absolutely right, too.

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

Audrey Wise

376. There is concern about the number of suspensions; my question, which triggered this, related to clinical competence?

(Mr Hassell) I think the debate we have been having for a little while now is very, very important, and I think all of us would share concerns, and I think it illustrates, again, why our request for there to be common regulatory systems is important. We were talking earlier, of course, and what is important is that we put the patient at the heart of all these discussions, whether it be about the effectiveness of treatment or issues relating to the doctor, and somehow, I think, we do need to move to a situation where there is the transparency and exchange of information that we have just been discussing.

Mr Lewis

377. Can I just make one point on the same issue. From my point of view, it would not just be about clinical incompetence. I would not imagine, I might be wrong, that it is easy, from a professional point of view, for a doctor to be suspended within the context of the National Health Service. So if the National Health Service were to make that decision that the grounds justified suspension, it may be fraud, it may be exploiting a patient financially, it could be all sorts of reasons, then, surely, there is a strong case for saying that anybody who is suspended, under any circumstance, from the NHS should also not, during that period, be able to practise, should be suspended, basically, by the private sector as well?

(Dr Vallance-Owen) I think, Chairman, that most of us would support the premise that you are innocent until proved guilty, unless there is an issue about patient safety. I think, on that occasion, that is the time when you have to override the presumption of innocence during an investigation, and if there is any question of patient safety then all of us act immediately, and I think that would be my answer to you. Sometimes it is a grey area and you have to look at a case on its merits, but, essentially.

(Mr Auld) I would say, Chairman, that if further exploration of this area were felt necessary by the Committee, I think that the opinion of the General Medical Council in this area would be fundamental.

Chairman

378. It is a crucial area, as I am sure you appreciate, yes.

(Mr Auld) I would have to say, that, in the main, the aim is the body that is best equipped to deal with a medical ethical issue of that nature. And I think, as we have indicated, we are more than happy (a) to collaborate with the General Medical Council, and (b) to engage in discussion, which has already happened in areas of validation, and to say "Fine; please, we'll take your guidance on this, we'll be very happy." If, as Mr Lewis is suggesting, there is an absolute black and white, suspension in the NHS should mean suspension everywhere. If that was a General Medical Council view we would find it pretty difficult to resist it, because it would be the rules governing the conduct of a consultant wherever he, or she, practises.

Chairman: Do you want to pursue the complaints issue, Ivan?

Mr Lewis

379. Yes. We want to look at the whole area of complaints, and some of you were here when we heard from relatives of people who, however we define death, most definitely had died in very unfortunate and tragic circumstances. And one of the kind of additional points to the trauma was the way that they felt they were dealt with after the tragedy, when there were a number of questions, legitimate issues, that they wanted to raise, and they felt that there was a deliberate wriggling out of responsibility and passing the buck amongst different individuals, different organisations, which did not enable them to feel that their complaint was being taken seriously. We have got the relationship between the patient and the admitting consultant, yourselves, the hospital board, and also the insurer, and there was a general feeling that there was a lack of clarity about where responsibility lay for investigating complaints, taking complaints seriously. So I would like to ask you about the policies that your organisations adopt, in terms of being clear about where responsibility lies, and being clear about, I think, from the beginning, even perhaps at the stage when you are promoting your services, how a patient has access to a clearly laid out complaints procedure, so what policies you adopt from that point of view?

(Mr Hassell) I think I touched on this earlier, Mr Lewis, and that we have had certainly a changing situation, in that we have, over this last year or so, been revising the IHA code of practice for dealing with patient complaints, and I think that new policy actually recognises the need for a more holistic approach to dealing with the complaints. I think it was touched on earlier; the Chairman, I think, was talking about the different contractual relationships. Now, particularly when there is a tragedy, it is the last time, not the occasion, to begin to talk about contracts, we recognise that, and that is why the new code of practice takes a different approach. But what one cannot escape from, at the end of the day, is that where litigation is perhaps pending, and this applies within the National Health Service as well as in the independent sector, then, of course, the NHS code of practice on patient complaints, or indeed our own, actually ceases to operate, because the legal system does take over that point. Now regarding the other points about information being made available to patients much earlier on, I think I am correct in saying, it would be interesting to hear comments from my colleagues, that every hospital, before an admission, will distribute to a patient various forms of handbooks or information sheets, which will include information on how complaints are handled within the hospital, so I think information is given at an early stage. I am not sure whether anybody would like to add to that.

(Mr Auld) For our part, Mr Chairman, I could direct the Committee's attention to an Appendix that we included in our evidence, that lays out the process for complaint, the way in which it does get handled. But these are for the routine. The majority of

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Mr Lewis Cont]

complaints that are dealt with are really about relatively small issues, certainly small by comparison with the tragedy of a death, and especially an avoidable death, which just devastates everyone, and there is no getting away from that. I think what Barry Hassell has said is a very important point, that, sadly, and this may well be just a fact that is difficult to escape or to legislate for. The very enormity of that incident tends to push the whole issue more towards litigation, and I am now saying NHS as much as the independent sector. The sheer size of the incident almost brings the idea of litigation that bit closer. Typically that is where, particularly given the consultant and the instructions that he is under from his medical defence union, it does start to restrict some of what in other circumstances would be much more of an open and more of a warm and sympathetic and caring approach. There is a little bit of a sense of retreat there. But I would encourage the Committee to look, and I am not sure if my colleagues have done the same with their complaint policies, at how these policies have developed over time and how we have listened to the representations of patients and of patients' parents and of patients' daughters and other people who have suffered particularly important tragedies within the private sector, and how our policies have moved on. Ultimately, I would stress again, we are advocating that if it could be possible to have the Ombudsman look at complaints within the independent sector, we would advocate that and we would welcome it.

(Mr Ervine) As so many times, my colleagues have covered the point I wanted to make, but I think an area I would like to emphasise is our wish to see an independent arbitration element at the end of a complaints procedure, if there is not satisfaction generated somewhere along that road, which at the moment we have not got because of these complexities that you talked about earlier; we see this as one of the fundamental ways of trying to build in this final element of satisfaction. But, as I think I said earlier, in a slightly different context, participation in it must be compulsory, because if somebody decides they do not want to play then the whole thing collapses, and so that is very much what has brought us to a method of compulsory arbitration; it could be the NHS Ombudsman. If we cannot get that successfully then we will have to try to build something internally, and that is what we have already started to do, in various ways, but we would much prefer it to be this universal process, frankly.

380. Can I come back. I think there are still issues. Do you regard the balance of responsibility for dealing with a complaint to be the responsibility of yourselves, as managers of the hospital, or with the individual consultant? I do not think you spelled that out at all.

(Mr Ervine) If I may just pick up that particular point. I do not think there is any doubt in our minds. If we have got a dissatisfied patient, we are very enthusiastic to actually resolve that dissatisfaction, because, at the end of the day, the dissatisfaction will attract attention to us just as much as the consultant, in fact, probably even more.

(Mr Hassell) Can I make one extra point, and that is, of course, comparisons are often drawn with the NHS Ombudsman scheme, and there are reasonable

comparisons to be made, but it has to be recognised that the Ombudsman's powers have only extended, just over a year ago, maybe 18 months ago, to include looking at complaints against hospital consultants; so that is actually quite a new development there. And I think that the sector actually has led the way in developing the way in which patient satisfaction surveys take place, that has been a standard procedure in hospitals for years, in the independent sector, and one which the NHS is now picking up, and I think, with the volume of work that takes place in the sector, we have a good track record. Now, I think, as everybody has acknowledged, when there is an untoward incident or a death they are absolutely devastating, and I would be quite happy to circulate to the Committee again the IHA code of practice, and you will see, within there, that it makes quite clear, as indeed do the Private Practice Forum publications, that the consultant has to be involved, and accept, as part of his admitting privileges, involvement in a complaints process. Things have moved on, we have recognised perhaps some of the shortcomings in the past.

381. So you would accept that the GMC code, for example, says that doctors have a duty in a situation where something goes wrong to explain why it went wrong and, if necessary, to apologise and admit responsibility, you would accept that?

(Dr Vallance-Owen) Absolutely, yes.

382. But you would also accept that perhaps in too many cases patients do not feel that that happens, and that it is very easy, where there are these complex relationships, different relationships, between the patient and yourselves and the consultant and the insurers, that perhaps sometimes there is a temptation for people to be passed from pillar to post, for people to be reluctant to acknowledge responsibility; do you accept that happens?

(Mr Hassell) I think it may have happened, and I think the message I would like to leave you, very clearly, is that every time there is an untoward incident lessons are learned from that, and I think the issue of how doctors communicate has perhaps been documented well elsewhere, and it is not for me to comment on. But I would like to leave very clear messages with you that the way in which patient complaints are handled is of the utmost importance to every one of the hospital groups, and we will see a totally new method of handling the complaint in the future.

383. Can I add two other quick points. That where the Registered Homes Act is relevant, in terms of a particular complaint, then the health authority, obviously, has a role, ultimately, in investigating that complaint, and yet we are told that in the complaints procedures that exist, even the most up-to-date ones, the patient is not informed, in your complaints procedures, that the health authority has those powers and duties. If that is the case, I would wonder why that is not spelled out clearly; is that true, that that is not the case?

(Mr Hassell) I think, the issue of the powers of health authorities, there are different views amongst inspectors as to the powers they have. The wording, this is not quoting verbatim, but my recollection is that the officers have the powers to investigate where

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Mr Lewis Cont]

an issue affects the registration of the establishment; now that is interpreted in different ways by different officers throughout the country. But certainly those who interpret the regulation broadly will become involved in the investigation of complaints in hospitals, but it is an area which I think does need clarification and I think was recognised by the evidence that the registration officers gave.

384. So, rather than the individual inspector's judgement being ambiguous, you are saying that it is the law, is it not; the law will spell out clearly when the health authority has a role?

(Mr Hassell) I do not think it does spell it out clearly, that is the problem.

(Dr Vallance-Owen) It is inconsistently applied.

385. It is inconsistently applied, but the law is clear?

(Mr Auld) I believe it is inconsistently applied, yes.

(Dr Vallance-Owen) I do not think the law is clear.

(Mr Auld) Can I just, again, quote from the Department of Health's evidence. "Health authorities have no locus to investigate complaints other than those relating to conditions of registration, if the service being complained about was not NHS funded." Now what I suspect is that the complaints that you are talking about, Sir, are perhaps more to do with the elements relating to long-stay care, where it is about facilities, or whatever. Typically, I imagine, and I look to my colleagues for contradiction, that complaints relating to service in an acute hospital will relate to matters probably outside of the conditions of damp patches on the walls and taps that will not work, or whatever.

386. Sure; the only point I am making, through the Chair, is that where the Registered Homes Act does apply the health authority clearly has a duty and responsibility, and therefore it would seem logical that your complaints procedure should inform patients of that. That is really a pretty clear point?

(Mr Auld) I think that would be a very fair point, Mr Chairman. I think it just highlights again, if I may say so, the fact of the inadequacy of the current registration legislation for conditions relating to acute hospitals.

387. I just want your judgement about where a complaint is proven to be valid, where we would accept, at whatever stage in the process, that serious mistakes have been made, and we know of circumstances where that happens in the private sector, and then the damage has to be put right by the National Health Service, or the patient, for obvious reasons, chooses, does not feel that he has confidence in the private sector because of what has happened and chooses to go to the National Health. How do you feel about the financial implications of that, so, basically, with the National Health Service picking up the tab for clinical incompetence, which will have occurred in the private sector?

(Mr Hassell) I think, firstly, you made a comment about clinical incompetence. I would suggest that not all transfers are for that reason.

388. Absolutely, but where that is the case?

(Mr Hassell) I think, if I could say, that, firstly, according to a study, about 20 per cent of all transfers back into the NHS are planned transfers of NHS

patients. I think it is an important area, but it is certainly one where the patient's right to use the NHS has never been questioned, and I think that does remain an important point, Mr Lewis.

Chairman: That is not quite the point he is making.

Mr Lewis

389. What I am saying is, where there is, as a result of acknowledged, accepted, incompetence, a patient gets the wrong treatment, bad treatment, or whatever, and then that patient is forced or chooses to go back into the National Health Service to have that corrected, or there may be very severe long-term psychological implications, as a result of treatment going wrong in the private sector, should the taxpayer be forced to pick up the bill for the consequences of incompetent treatment in the private sector? That is the point I am making. Or should you yourselves be financially liable in those circumstances?

(Mr Pilgrim) I think, in circumstances you describe, absolutely the private sector, in some form, should have the responsibility for those costs, in the specific circumstances you describe.

Chairman

390. But that is not happening, as far as we can see; if it is happening then we have missed it. But are you saying—

(Dr Vallance-Owen) Certainly, I have had an example myself of a problem which occurred in one of our hospitals, which was clearly of our making; the patient did require transfer into the NHS and we certainly offered to pick up the tab. I think you have to look at cases on their merits. I know that sounds a bit weasel words, but you do, because it is not always clear whether what has happened.

Mr Lewis

391. That is okay, but is that the exception; you said "we offered to pick up the tab".

(Dr Vallance-Owen) Right from the start.

392. Which was an individual judgement that you made; but, across the sector, the point is, what we are trying to establish, what is normal practice in those circumstances. The NHS would carry the burden of the costs from that stage onwards, and would you feel, Mr Pilgrim, you said, you feel it would be right for the private sector to essentially fund the Health Service for the treatment it was having to provide?

(Mr Pilgrim) I think it is totally right. Frankly, our organisation and the consultants who work have insurance to cover just those eventualities, of the results of their professional actions. So I see it as being, it is probably a logistical issue as to the patient may not make a claim, but the patient needs to make a claim and then all the things will trip in.

Mr Lewis: I understand about compensation to individuals, who are the victims of clinical incompetence, or whatever, but I am talking about do those insurance companies then, in those

25 March 1999]

MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM

[Continued]

[Mr Lewis Cont]

circumstances, reimburse the National Health Service for the treatment that that individual then has to go on and have in the NHS?

Chairman

393. Can I illustrate with the point I raised, which some of you probably picked up from an earlier session, where we talked about the Bill that is going through Parliament, may have gone through Parliament, in respect of claims against insurance for accidents when people have been driving a motor vehicle, where the NHS has costs to pay. And I drew the analogy of what is the difference between contributing from an insurance policy, as a motorist, and contributing from an insurance policy for private medical insurance; where, if I am within BUPA, I am not suggesting something would go wrong in BUPA, but wherever, that I could not see a difference, in principle, between the Government requiring perhaps a contribution from the insurer to the costs of the NHS with its private medical insurance compared with car insurance. In principle, it seems to me, it is exactly the same thing?

(Dr Vallance-Owen) I am sorry, there is an issue. On the insurance side, if we have a member who is insured by us and something occurs to them in the course of their treatment, they will continue to be insured with us, and we certainly carry on covering their care if there is a complication. So that I do not think is an issue, as an insurer.

394. So if that complication cannot be dealt with within one of your own hospitals and they have to go on the NHS, you then would offer to pay for the costs of that treatment?

(Dr Vallance-Owen) If that patient is insured and the patient needs to go to the NHS for a more complex operation, to revise the problem, or whatever, yes, the insurer would pay, and, of course, 80 per cent of the cases are insurance covered. So I think most insurers would do that.

395. If that person is not insured and purchases an intervention in the private sector, a one-off payment for an operation of some kind, which does happen, and that goes wrong, what happens then, when there is no insurer?

(Mr Pilgrim) The difference is between, the exact definition you used, Mr Lewis, was of clinical incompetence, i.e. malpractice. I think, in those circumstances, the statement I made should apply, absolutely.

396. So you would accept liability for the costs of that treatment?

(Mr Pilgrim) We have insurance to cover that, and I think that is an acceptable part of—

Mr Lewis

397. So health authorities up and down the country, where these situations happen, I am not saying they happen a lot but where they do, would expect to be receiving income from insurers in such cases; if we asked health authorities "Where you are having to treat people, who, as a result of problems in the private sector, have had to come back into the

NHS", they should be telling us that, very small amounts, but they are getting income from insurers, in those cases?

(Mr Pilgrim) Yes, and I think the insurers are not the BUPAs and PPPs of this world, they will be malpractice insurers, behind our organisations.

Chairman

398. I am conscious that we have had you here a long time, but this is a very important area, and it may well be that you would wish to write to us further on this area, on what currently is happening within your own organisations.

(Dr Vallance-Owen) Yes.

Chairman: Because it is an area that clearly we are concerned with and inevitably impacts upon what we will be thinking about in terms of our report. Peter Brand.

Dr Brand

399. Can I ask just a very brief question of Mr Irvine. Do you now have a clearly spelled out complaints procedure on your literature, because I was worried, when we took evidence some weeks ago, the it took a long time for the relatives to find out how to actually proceed with a complaint?

(Mr Irvine) Yes; as of a number of years ago, and I cannot quote to you how many, probably something like three, there is a code of practice and a complaints procedure which appears in every patient's bedroom, and admitting booklets, things like that, which includes the facility to ultimately write to me, and various other things.

400. I would be grateful for a copy of that. Your evidence you submitted rather sort of assumes that everything will be rosy, unless it is so disastrous that you are into litigation, and it all seems very informal; whereas the great strength about a complaints procedure is that you have got to have a stepwise approach to it.

(Mr Irvine) Absolutely.

401. My practice leaflet has the internal complaints procedure on it, then the health authority, then the community health council, I have not mentioned the Ombudsman because at the moment he is a bit irrelevant, but one would expect the same approach; and I do not think that would need legislation, I think that is a good code of practice. And I was very surprised, when we heard a few weeks ago about an incident that happened within the last three years, that that was not available to people.

(Dr Vallance-Owen) I think most of us have a stepwise complaints procedure which escalates and we try to help the patient through the process.

(Mr Irvine) Yes. I would be very happy to send you a copy of that code of practice which mirrors the IHA's code of practice almost completely.

Dr Brand: Thank you.

25 March 1999]MR BARRY HASSELL, DR VALLANCE-OWEN, MR CHARLES AULD,
MR DAVID ERVINE AND MR ALAN PILGRIM[Continued

Mr Walter

402. This is a very simple question, to come on the tail; obviously, you, in your sector, provide some services where the National Health Service is buying from you; if one looks at the situation which has grown up over many years in the National Health Service, where National Health Service hospitals have private wings and pay beds, are they regulated?

(Mr Irvine) No.

403. At all, not at all?

(Mr Pilgrim) No.

Audrey Wise

404. Just to recap, so I am absolutely sure, did I gather that, in relation to complaints, a patient or a patient's family would receive a full explanation, an apology, if warranted, and a description of action to be taken to prevent recurrence?

(Mr Pilgrim) Yes.

(Mr Irvine) Absolutely.

(Mr Hassell) I have heard people just sort of muttering here, that it is contained within the policies.

405. All you need say is yes?

(Mr Hassell) Yes.

Chairman

406. Do any of the witnesses want to make any further points?

(Mr Hassell) Could I make just a couple of points. Firstly, I think it is important to that last question about liability, that Mr Lewis was mentioning. One of the things that I think it is important to tell the Committee, rather than just to submit to you, is that under an Executive letter in 1995, and certainly I would let you have the references, it clearly said that the right to free NHS services under the NHS Act, the

1977 Act, is an underlying one, and does not cease to exist simply because the patient in question is receiving private treatment. So I think that the NHSE is quite clear about their position, and I thought it important you should know that.

407. I think the difficulty there was, I understand that, and, clearly, if something occurs when a person is in a private hospital that cannot be dealt with in that private hospital, there is nothing to stop them being referred to the NHS, we would expect that, in every case. I think the concern was more related to where something is accepted to have gone wrong, clinically, as a consequence of problems in the private sector; that was the main thing. I am grateful for that information.

(Mr Auld) Could I just commend to the Committee some attention paid to a regulatory system that is universally applied across the National Health Service and the independent sector. It is operating in a robust, universal way. It is, by all accounts, extremely successful. It is extensive. It is getting into over 100 clinics which are involved in fertilisation, and embryology. It is being run by the HFEA, and, by all accounts, it is working very well. The important thing is that it underscores our advocacy that universality of approach not only is eminently suitable but, by dint of that example, is achievable.

Chairman: Can I thank you all for a very helpful session, we have had some very useful information, and, once again, express our gratitude for the written evidence that you have given, which has been most helpful. I believe we will be seeing one or two of you, possibly, in three weeks' time, looking at mental health; we look forward to that. And we thank you once again for coming in today. Thank you very much.

THURSDAY 15 APRIL 1999

Members present:

Mr David Hinchliffe, in the Chair

Mr John Austin
Mr David Amess
Julia Drown
Mr John Gunnell

Mr Ivan Lewis
Mr Robert Walter
Audrey Wise

Memorandum by Westminster Health Care**THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTH CARE (PM 73)****EXECUTIVE SUMMARY**

Regulatory standards are inconsistently applied across England, Scotland and Wales.

Staffing Levels

Staffing levels are set applying guidelines which take no account of building efficiency and the capability of the Operator. Individual staffing agreements by facility are required.

Review of Staffing Levels and Skill Mix

We can significantly reduce skill mix by the redefinition of roles; this will create a greater availability of trained nurses but it is often impossible to run trials, to experiment with reduced skill mix without risking prosecution for failing to comply with minimum staffing levels.

Regional Variation

Staffing levels by region based on the views of Registration Officers and an illustration is provided.

More Output Based Regulation is Required

Input based—how many staff on duty and what size is the room.

Output based—what do they do and does it serve the intended purpose.

Vetting of Persons in Charge

Many Registration Officers have too much authority in the appointment of the person in charge of a nursing home. They should be available for advice, knowledge of prior performance but they should not be able to veto appointments except on the grounds of:

- health/fitness;
- appropriate qualifications;
- police check of relevant criminal offences.

Complaints Procedure

The risk of reprisals from Registration Officers can effect referrals—the commercial impact means few complaints are issued against heavy-handed Registration Officers.

Registration of New Homes

The upward climb of minimum standards is increasing development costs to a point where a viable return is impossible to achieve.

The post First World War boom will require more registered care home places by 2005, the point at which the key age of 85, being the age of admission to a nursing home, is achieved.

The regulatory climate should be one of encouragement rather than one of restriction.

15 April 1999][Continued

Registration Officers

The focus and style of a Registration Officer is a significant factor in how Regulation is conducted.

GENERAL OBSERVATIONS

There are numerous areas of regulation which deserve comment but the following notes focus on those areas where we believe in the main the regulatory process is obtrusive, often heavy handed and in our view, can be counter productive to achieving a quality outcome.

Staffing Levels

There is a general preoccupation with applying staffing levels across a Health Authority area without recognition of the quality of the operator or the efficiency of the building. Registration Officers are equally preoccupied with the fear, which we believe is non-existent, of creating precedents which other operators will use to negotiate staffing levels downwards. Staffing levels should be agreed on an individual basis recognising systems, procedures and the efficiency of the building.

Review of Staffing Levels

The Act requires that only Health Authorities can review staffing levels and this is invariably upwards. In a recent case, one Health Authority refused to consider our request but invited us to reapply for the registration of a large nursing home. There is no mechanism where operators for legitimate reasons can review staffing levels without the consent of the Registration Officer which can easily be withheld.

Skill Mix

Skill mix is a general phrase to reflect the number of qualified nurses as a percentage of a total number of hands-on care staff. When nurses were in greater supply skill ratios of 40 per cent were not uncommon but at the present time the norm is between 30 and 33 per cent.

Companies such as Westminster have been running trials and we are currently carrying out a monitored research exercise which will examine means by which skill levels can be reduced to 25 per cent or below.

If applied nationally, these could have a significant impact on the number of qualified nurses required by the sector in a climate when there is a severe shortage but without negotiated prior agreement most Registration Officers take the view that "the walls of Jericho are being breached" and are very reluctant to consent to trials. Furthermore, in experimenting with different models of care we expose ourselves to the risk of prosecution.

Staffing Levels—Variations by Geographic Region

There are considerable inconsistencies in staffing levels which are determined by nothing other than the dominance of a Senior Nurse or an influential Registration Officer—the personality factor.

In a recent case, we provided extensive evidence that a 30 bed unit could be operated with three at night, a ratio of 1:10 which is common throughout the sector but one Health Authority, because their guidelines (which are very old) insisted on four being provided. We have spent considerable time, effort and money in resisting this claim, providing comparative evidence of 12 other identical units and the evidence of a respected Registration Officer from another part of the country. All this was completely ignored because the guidelines required four members of staff on nights! Inspection reports were satisfactory.

Input Based Against Output Based Regulation

If there is one shortcoming in the recent White Paper it is the lack of recognition of the need for an output based regulatory mechanism and the pre-occupation with an input based mechanism.

In essence:

Input based—how many staff on duty and what size is the room.

Output based—what do they do and does it serve a purpose.

15 April 1999][Continued

The Subjectivity of Registration Officers

To further develop the importance of moving towards an outcome measure a somewhat anecdotal experience serves to illustrate the view. Criticism is often made of small, privately run nursing homes, often conversion, often inappropriately laid out but run by a caring proprietor and they create an atmosphere which is conducive to a happy life for the residents. Many an Inspector would visit such a home, criticise the appalling standard of the kitchen or border line Health & Safety practices but would see a caring motivated staff group and happy residents.

By comparison, one sees large nursing homes with residents asleep, watching a silent television with their heads back and mouths open. All too often, the purpose built home fully satisfies registration requirements, is regarded as a satisfactory nursing home by the Registration Officer but we would all put our mothers in the small home and accept the risk of the odd tummy upset.

Vetting of Persons in Charge

Many Health Authorities restrict their vetting to the following:

- Health/fitness;
- Appropriate qualification;
- Police check to identify relevant criminal offences.

These Registration Officers take the view that the recruitment of the Manager is the operator's responsibility and measure the appropriateness of the appointment as an outcome measure at the next inspection. If they feel competencies are lacking then it is brought to our attention.

Other Registration Officers extend the process to include:

- Interview by the Registration Officer;
- Examination of competencies;
- Setting experience criteria such as two or five years in a similar position.

We have extensive exchanges of correspondence where Registration Officers refuse to accept a registered person because of the additional criteria which is unsettling and demoralising for the individual and we believe is an abuse of the Regulators power and a bad illustration of bureaucratic power playing.

Registration of New Homes

The minimum accommodation standards and the individual preferences of a Registration Officer, ie the inconsistencies which are widespread across the UK have discouraged operators such as Westminster from developing in recent years. The consequences of ever increasing standards has pushed up the cost of construction such that the present fees paid by Social Services make a viable return impossible to achieve.

This is made more difficult by Registration Officers imposing additional standards which, with the withdrawals from the market and the increasing population of older people in the 85 age range—the post First World War boom coming into the critical age of 85 for admission to long-term care is in danger of causing a shortage of long-term beds in the new Millennium. The climate of regulation can have a significant impact on the level of development and at the present time, the climate is restrictive rather than encouraging.

Complaints Procedures relating to Regulation

We have rarely complained but have had numerous causes to do so. The risks of reprisal are real and the Registration Officer often has considerable influence particularly where “a word of warning” is expressed to a Purchaser which can have a significant impact on referrals but is impossible to prove.

Summary

In summary, the points outlined above invariably focus on staffing because it represents around 55 per cent of operating costs. Thereafter, the process becomes facility based with a sensible focus on health and safety issues, ie safe hot water and legionella precautions.

The process is insufficiently facilitative and with the introduction of Open Reporting has become cumbersome.

February 1998

15 April 1999]

[Continued

Memorandum by Priory Healthcare**REGISTRATION OF INDEPENDENT MENTAL HEALTH NURSING HOMES (PM 27)****INTRODUCTION**

Priory Healthcare is the UK's leading independent provider of specialist treatment for people with mental health needs, running units such as:

- 14 acute mental health hospitals with approximately 600 beds;
- two residential units offering special education; and
- two specialist adolescent units offering treatment for addictions and eating disorders.

Priory Healthcare is committed to offering the highest possible quality of care, to the continued development of clinical practice within all mental health services, and to working in partnership with health and social services to meet the mental health needs of the population.

REGULATION OF PRIVATE ACUTE MENTAL HEALTH SERVICES

The system of regulation proposed would be an improvement on the inconsistent and confusing systems currently in place however, as proposed, ignore the need for continued regulation of private acute mental health providers. If providers are not included in the final proposals there is the risk of period of unregulated provision which will not benefit the patients, providers or purchasers within this industry. Since a significant minority of our patients are NHS-funded, this would result in NHS patients being treated by unregulated providers.

PRIORY HEALTHCARE LTD

Priory's success is directly due to the quality and training of staff and to the excellent facilities available at our hospitals and units around the UK. The needs of individual patients and their carers are central to our clinical practice, and our patient-centred treatment programmes include an extensive range of therapies.

In line with our aim to provide the appropriate intensity of care to each individual the Priory is able to offer the following range of interventions:

- home-based/community-based services;
- outpatient services;
- daypatient services; and
- inpatient services.

This range ensures that the patient's health and well-being can be restored as quickly as possible, whilst delivering value for money to purchasers, be they private medical insurers, corporate client, the NHS or the patients themselves.

Of particular importance is good liaison with referrers and purchasers (through assessment and regular reports, meetings and discharge planning) to maintain involvement with other relevant agencies. Our services work with other health and social services to ensure continuity of care to the patient, where required.

The exact range of treatment programmes and therapies available is at the discretion of each hospital. They are encouraged to develop their own specialities in order to meet the needs and complement their local healthcare environment.

TREATMENT PROGRAMMES

Addictions/treatment	Post-natal depression (mother and baby care)
Programme/alcohol/drug abuse	Post traumatic stress disorders
Adolescent psychiatry	Psychogeriatric disorders/old age
Anxiety problems	Psychiatry
Bereavement and loss	Psychological symptoms resulting from physical disease
Chronic fatigue syndrome	Relationship difficulties
Depression (including resistant depression)	Secure facilities
Eating disorders	Sexual dysfunction
Family problems	Somatoform/sleeping disorders
Marital problems	Stress disorders
Obsessive compulsive disorders	Transcultural psychiatry
Occupational Mental Health	Workplace related emotional problems
Phobias	

15 April 1999]

[Continued]

CARE STANDARDS

Ideally we would hope to see a consultative framework where leading organisations in the private healthcare market, including private medical insurers, the Independent Healthcare Association, the Royal Colleges etc, agree care standards. We welcome the contribution that the National Institute of Clinical Excellence will take to these standards. Implementation would then be monitored by the regulatory authority. In the proposed model monitoring could be carried out by the eight regional services.

A single set of care standards would help to ensure consistency, both in the standards used nationally (thereby helping to minimise geographical inequalities of care) and with the standards agreed within the industry through contracting. In operating a mixed economy of care, consistent implementation of best practice must be a prime consideration.

REGULATORS

We would expect to see current practitioners of acute mental health care as core members of the regulatory body. In addition to current qualifications and experience, a statutory inspection accreditation would be useful, requiring periodic re-accreditation. We would be happy to support the training and professional development requirements of such an inspectorate.

We would expect the regulatory authority to be self-financing through the payment of registration fees, and that inspection reports were made publicly available as a resource to help the consumer in choosing between providers.

In addition, we would hope that the regulatory authority can take on a complaints ombudsman role.

VISITS

We would suggest including the Roehampton Priory Hospital, Eden Grove School, and the adolescent unit at Grovelands Priory Hospital as visit sites in order to demonstrate the range of services provided by Priory Healthcare.

ORAL EVIDENCE

Priory Healthcare would welcome the opportunity to give oral evidence to the Select Committee if required.

Memorandum by St Andrew's Hospital, Northampton**INSPECTION REGULATION (PM 20)**

1. This memorandum seeks to look at the Inspection Regulation currently in the Independent Sector for Psychiatry and Substance Abuse. The memorandum will argue that there is already considerable regulation and inspection in the Independent Registered Mental Nursing Homes Sector, that is the Independent Psychiatric Hospital and that regulation is patchy at best and lacking at worst in some other parts of the Sector.

2. I am Dr Michael J Harris, Medical Director of St Andrew's Hospital, Northampton. I am also Chairman of the Psychiatric & Substance Abuse Committee of the Independent Healthcare Association and a member of its Acute Board. I am a Consultant in general and forensic psychiatry and have previously been a Consultant Forensic Psychiatrist and Medical Director of Nottingham Healthcare NHS Trust. I was a Sub Dean of the Royal College of Psychiatrists for five years between 1992 and 1997 and I have also, at various times, been a member of the Rampton Hospital Advisory Committee, a member of the Nottingham Probation Committee, visiting Psychiatrist at HM Prison, Nottingham and HM Prison, Lincoln and Chairman of MIND in Nottingham. I am also currently a member of the Central Consultants Specialists Committee of the BMA.

3. I will comment only on the Regulation, Monitoring and Inspection of the Psychiatry and Substance Abuse Sector. Provision of services for people with mental health problems and substance abuse difficulties fall largely into four different types of organisation:

1. Independent Practitioners providing out-patient treatment.
2. There are the provision of long stay residential nursing homes, those with mostly organic mental disorder, particularly dementia. There are provision of a very large number of rehabilitation units for substance abuse, most of these are within the voluntary sector and there is the provision of Registered Mental Nursing Homes that are in reality Independent Psychiatric Hospitals. These are both in the voluntary (charitable) sector and privately funded.
4. The Registered Mental Nursing Home Sector, the sector in which I currently work and have most

*15 April 1999]**[Continued]*

knowledge about is one of the most heavily inspected and regulated sectors of the health provision in the UK. Registered Mental Nursing Homes are regularly inspected by the Mental Health Act Commission, the Health Committee will of course be aware that the Mental Health Act Commission in England and Wales and the Mental Welfare Commission in Scotland have the power to visit any institution in which patients can be detained under the relevant Mental Health Act. They can make those inspections either by arrangement or at the drop of a hat and for hospitals working in the independent sector, the Commission make regular visits, both routine inspections and patient focused visits including unannounced visits. Registered Mental Nursing Homes are, like any other nursing home, also subject to inspections by the Nursing Homes Inspectorate. NHI Inspections have become increasingly rigorous in the last 12 months and for those Registered Mental Nursing Homes who also do a substantial amount of their work for the National Health Service, they are subject to inspection by the Health Authorities who place contracts with them.

5. In reality, it is usually only those Health Authorities who have a substantial financial commitment to a particular hospital that do undertake such inspections but very often, they will act as agents on behalf of other Health Authorities. In addition, all those hospitals in membership of the Independent Healthcare Association's Psychiatry & Substance Abuse Committee are committed to taking part in one of the standardised forms of external audit, most commonly, either the King's Fund organisational audit (HQS) or ISO 9000 Inspection. These are rigorous audits undertaken by outside bodies that look to see whether systems and processes to safeguard the quality of care are in place.

6. The Independent Registered Mental Health Nursing Home Sector, that is the Independent Psychiatric Hospitals, undertaken between 10 per cent and 12 per cent of all in-patient psychiatric activity in the UK. In addition 55 per cent of all the country's medium and low secure psychiatric beds are in the independent sector, as are the very large majority of beds for people with combinations of learning disability and challenging behaviour requiring conditions of security and for adolescents with mental health problems and challenging behaviour requiring conditions of security.

7. This sector which does a considerable amount of its work for the National Health Service and which provides a considerable service to the NHS, is also currently subject to stringent regulations. Over the last three years, the Independent Healthcare Association Psychiatric & Substance Abuse Committee has also regularly met with the Royal College of psychiatrists in order to look at the interaction between the Independent Sector and the National Health Service in the provision of care and the quality of the care provided. Out of these regular meetings have come two papers on standards of care for the elderly in the Independent Mental Health Sector and on the interface between the Independent and the Statutory Sectors in the care of the elderly and papers on the interface between the Independent Sector and the NHS on the provision of forensic psychiatric services and agreements by the Independent Sector to follow National Guidelines on the appointments of Consultants within the sector. In reality, the majority of Consultant Psychiatrists working in the Independent Sector have held substantive NHS Consultant appointments previously, or are in possession of a certificate of completion of specialised training or are on the Specialist Register, having completed their Senior Registrar training within the NHS (or the Armed Forces).

8. The provision of substance abuse services is largely open to inspection by the Social Service Inspectorate as most of these are in fact residential care homes, a small amount of such work being done in Registered Mental Nursing Homes but the same requirements would apply as for care of psychiatric patients within this group. Many of the placements in the independent sector, addiction rehabilitation facilities are funded by the Statutory Sector, particularly social services and again should be open to inspection by the funding authorities. It is not clear to what extent funding authorities do in fact inspect the quality of these facilities.

9. Registered Mental Nursing Homes that are not in reality psychiatric hospitals. These are similar in character to other nursing homes for the elderly or those with learning disability. Many are also registered as residential care homes and as such are open to inspection both from social services and from the Nursing Homes Inspectorate. For those that have substantial contracts with the NHS, they are usually subject to inspection by local psychiatric services. However, the majority do not fall into this category. Those in membership of the IHA are subject to a voluntary code of practice in which they would agree to external audit. However, as very few of these nursing homes are Registered Mental Nursing Homes, they are not subject to inspection by the Mental Health Act Commission and the majority will only receive their inspections from the NHI. Again, however, this is increasingly rigorous and the standard of care in most such facilities is having to improve following inspection. I believe that the Royal College of Psychiatrists has agreed to nominate an appropriate local psychiatrist to join the Nursing Homes Inspectorate for visits to such institutions where the Nursing Homes Inspectorate believes this will be useful.

10. Finally, the provision of Independent Sector consultation. Clearly, this is the least well regulated sector. Patients make contracts with individual practitioners for the medical profession who are clearly subject to professional registration as are those who practice as Chartered Psychologists. For all other groups however, they may operate within the Code of Practice and Ethics of some learned societies such as the Institute for Psychoanalysis or be subject to membership of the United Kingdom Council on Psychotherapy (UKCP). However, it is still true that anybody can set themselves up as a counsellor or psychotherapist in private practice, as long as they do not belong to one of the state registration authorities.

*15 April 1999]**[Continued]*

11. In summary therefore, the four sectors in the Independent Sector that provide care for people with mental health and substance abuse problems are variably regulated. The hospital provision, Registered Mental Nursing Home, is highly regulated and indeed is more regulated and inspected than the equivalent NHS facilities.

12. The independent sector substance abuse facilities are variably regulated but mostly are inspected by Social Services as Residential Care Homes.

13. The Nursing Homes Sector is subject to inspection by the Nursing Homes Inspectorate and Social Services Inspectorate as very often these are duly registered.

14. Independent practitioners are the least well regulated sector especially those who are not subject to state registration.

15. The Independent Healthcare Association Psychiatry and Substance Abuse Committee is of the firm belief that inspection is necessary for the care and safety of the patients who are looked after in this sector. As a group however, we have a concern that regulation is uniform, both within the Independent Sector and the Statutory Sector. As an individual, I would also voice a concern that individual practitioners should be subject to a form of state registration and quality audit on their qualifications for undertaking individual psychotherapy counselling or treatment and their ability to update themselves in order to protect the public.

December 1998

Supplementary memorandum by St Andrew's Hospital, Northampton

MENTAL HEALTH (PM 20A)

1. This memorandum presents the views of St Andrew's Hospital, Northampton, on the inspection and regulation of the independent provider sector in mental health, substance abuse, developmental disabilities and brain injury services to present to the Parliamentary Health Committee investigation into the regulation of that sector.

2. St Andrew's Hospital, Northampton, is the country's largest independent psychiatric hospital. St Andrew's is a registered charity run by a Board of Trustees (the Governors). St Andrew's Hospital has provided psychiatric services to the people of Northampton and the United Kingdom for over 160 years. St Andrew's Hospital provides services in the fields of General Adult psychiatry including addiction disorders and eating disorders, Brain Injury Rehabilitation, the care of elderly people with organic and functional mental illness, including those with challenging behaviour, services for adults and adolescents with developmental disorder (Learning Disability) and challenging behaviour and services for adolescents and adults of normal intelligence with a combination of mental illness and/or personality disorder and challenging behaviour. St Andrew's Hospital provides approximately 30 per cent of all the UK's brain injury rehabilitation beds, approximately 22 per cent of the beds for people with learning disability and challenging behaviour and approximately 6 per cent of the UK's adult mental illness medium secure beds as well as approximately 50 per cent of the UK's medium secure beds for adolescents with mental illness and challenging behaviour.

3. The independent sector provides approximately 20 per cent of acute, inpatient psychiatric care, 81 per cent of all brain injury services, 30 per cent of medium secure care and 44 per cent of residential care for learning disability as well as the majority of residential care for those requiring treatment for substance abuse and the elderly.

4. The independent sector employs either full or part-time approximately 11.5 per cent of all consultant psychiatrists in posts. Including those consultants with admitting rights, approximately 25 per cent of all consultant psychiatrists have an involvement with the independent sector. Consultant psychiatrists in the independent sector are subject to the same stringent requirements for employment as consultant psychiatrists in the National Health Service. The vast majority of consultant psychiatrists in the independent sector have previously held consultant posts within the NHS.

5. The treatment of people with mental health and substance abuse problems in the independent sector takes place in a number of different settings:

- (a) outpatient clinics;
- (b) acute inpatient units;
- (c) medium secure units;
- (d) twenty-four-hour nursed care;
- (e) residential social care;
- (f) nursing homes;
- (g) independent psychotherapy and counselling practice.

*15 April 1999]**[Continued*

6. The current inspection and regulation of these different settings is described below.

- (a) Inpatient units are effectively independent psychiatric hospitals although regulated as "nursing homes". These have regular inspections from both the Mental Health Act Commission and the Nursing Homes Inspectors of the Health Authority under which they are registered. For those units that take NHS patients (the majority) they are also subject to inspection from the purchasing authorities. For the minority that have psychiatric training posts they are also subject to inspection by the Royal College of Psychiatrists;
- (b) Twenty-four-hour nursed care units and nursing homes are subject to inspection by the registering Health Authorities;
- (c) Residential social care which includes psychiatric rehabilitation hostels, units for the treatment and rehabilitation of those with substance abuse problems, units for those with learning disability, brain injury or the elderly are subject to inspection by Local Authority social services;
- (d) Those practising independently in outpatient settings or in independent psychotherapy or counselling practice are subject only to the regulation of their professional registration authority where there is one (for example the General Medical Council for medical practitioners).

7. St Andrew's Hospital believes that there is a need for regulation, inspection and audit across the whole of the independent Psychiatric and Substance Abuse sector. The Hospital believes that regulation and inspection in the independent hospital sector that is covering acute admissions and medium secure admissions is currently well done with the inspections from Health Authorities and the Mental Health Act Commission. The Hospital believes that inspection would be improved with the recognition that independent psychiatric hospitals are hospitals with provision of nursing care and resident medical cover and are not nursing homes. This, in turn, could lead to inspection by appropriately qualified, multi-disciplinary teams or maybe, an addition to the current Mental Health Act Commission inspection teams.

St Andrew's Hospital does believe that there is an issue on the quality of inspection and regulation of the independent nursing home sector. This gives rise to a large variability in the quality of care provided, particularly to elderly people and people with learning disability cared for in that sector, with some excellent operators and others providing substandard care. An improved and better funded registration authority inspection team with professionals from all relevant disciplines and with national standards for inspection in practice would help to improve the quality of care across the whole of the United Kingdom.

St Andrew's Hospital believes the registration and inspection of individual practitioners practising independently presents particular problems. For those who have national registration, such as medical practitioners and psychologists, there is the safeguard of the registration authority to which the patient or client can complain and from whom they have some redress. Yet in the fields of Psychotherapy and Counselling, it is possible for anybody to set up in such practice and, if they are not a member of a recognised profession with a state registration, then there is no redress for the individual client. There should, as a minimum, be an insistence on registration with one of the organisations represented by the UKCP or the BCP. There also needs to be a recognised right of complaint and redress for patients or clients consulting in that situation.

SUMMARY

8. St Andrew's Hospital believes that the independent Psychiatric and Substance Abuse sector is represented by different methods of practice. It is suggested that the inspection process could be improved by the employment of appropriate, multi-disciplinary inspection teams. There is a concern that the inspection and regulation of the nursing homes sector is less well regulated and these teams could monitor and audit services against agreed clinical/performance standards. The Hospital believes that practitioners working in independent outpatient practice should be subject to professional registration with authorities that give the public right of access and redress in case of dissatisfaction with the service provided.

19 January 1999

15 April 1999]

[Continued

Examination of Witnesses

MS CAROLINE QUEST, Executive Director, Mental Health, Independent Healthcare Association, MR PETER FARRIER, Managing Director, Partnerships in Care, General Healthcare Group, MS MARGARET CUDMORE, Director of Development, Westminster Health Care, MR STEPHEN PAGE, Director, Priory Healthcare, and DR MICHAEL HARRIS, Medical Director, St Andrew's Hospital, Northampton, were examined.

Chairman

408. May I welcome you and offer my apologies for the slight delay in starting. We had a lengthy private session agreeing a draft report on other issues. Thank you for coming before us and for the written evidence that has been submitted, which is very useful to the Committee. Perhaps I may begin by asking witnesses to introduce themselves briefly to the Committee.

(*Ms Cudmore*) I am Margaret Cudmore, Director of the Specialist Health Services Division of Westminster Health Care.

(*Mr Farrier*) Peter Farrier of General Healthcare Group, Managing Director of Partnerships in Care.

(*Ms Quest*) I am Caroline Quest, Executive Director for Mental Health at the Independent Healthcare Association.

(*Dr Harris*) I am Mike Harris. I am a psychiatrist and Medical Director of St Andrew's Hospital in Northampton.

(*Mr Page*) I am Stephen Page and I am a Director of Priory Healthcare.

409. May I begin by asking you some general questions. Clearly we are concerned specifically in this session with looking at the psychiatric health provision in some detail. It is quite clear to us that there are some marked distinctions between the regulation of provision in the medical sector and that for the psychiatric sector. I wonder if any of the witnesses would feel able to explain these distinctions and clarify how they may relate differently first to informal/voluntary patients who are agreeing to be in some form of provision, and secondly to patients who are under some form of section or restriction. Mr Farrier, do you want to open?

(*Mr Farrier*) Within my own experience the facilities we provide are in the main for detained patients. In that respect we comply with the regulations of the Mental Health Act. I am not that experienced in the care of those that are informally detained. Perhaps one of my colleagues with more experience in that would like to take that question.

(*Ms Quest*) As far as the informally detained patients are concerned the main way in which the sector is regulated is through the 1984 Registered Homes Act and that is by health authorities. The sector is also regulated by the purchasers of services which would include health authorities. It would also include the private medical insurers and the Mental Health Act Commission would be the main body that is regulating the detained patients.

410. Can I ask you where you see distinctions in the quality of supervision between those two areas in respect of the informal patient and the sectioned patient because of the different procedures that exist? Do you perceive that there are distinctions? Do you perceive that one system is working better than the other?

(*Ms Quest*) I think that is correct. We have experienced as a sector that the Mental Health Act Commission is more appropriate in terms of its regulation of detained patients under the Act than the somewhat outdated 1984 Registered Homes Act is for informal patients. Our main problem with the Registered Homes Act is that its focus has tended to be on hotel facilities if you like not necessarily, but it is not as focused on patient treatments and on outcomes as we think it should be and that it is also implemented quite variably around the country. Importantly, there is felt to be a lack of mental health expertise within the registration units, although again this is patchy. When one considers the size of independent mental health care provision, if we put it in context and think that this is a sector which is providing a fifth of all acute care and within the specialties much higher proportions, as you know from the written evidence: the majority of care for the elderly mentally ill, the majority of care for people who have acquired brain injury, the majority of care for people with addiction problems, this is why we have been calling for a modernisation of the regulatory system, particularly for the informal patients, although we welcome the review of the Mental Health Act which I am sure will also go some way towards modernising inspection.

(*Mr Page*) I would agree with my colleagues in terms of the informal patients having less regulation than the formal patients and the expertise available for the detained patients is very valuable. We also as an independent sector, like many NHS trusts, have our internal quality procedures and increasingly have procedures for clinical governance, clinical audit and the like, which are part of that quality and governance. This information is available to the registration officers and also to the Mental Health Act Commission and acts as a sense of reassurance for them.

411. I am very conscious that clearly in the sector that you are dealing with there is far less involvement of medical insurance because, as you indicated, many of the patients are directly placed by the National Health Service. What are the implications of the fact that there is less involvement of medical insurance for the quality questions when comparing it with the acute medical sector?

(*Ms Quest*) What we have tried to do, in the absence of what we would say is appropriate statutory regulation, or at least modernised statutory regulation, is that we have made attempts at self-regulation, I think successfully. We have quite a sophisticated array of self-regulatory mechanisms and I would draw to your attention the IHA's code of practice which was appended to the written evidence for the psychiatric membership. We have also got the Academy of Medical Royal Colleges' Private Practice Forums quality framework which is focusing on clinical governance. In addition there is

15 April 1999]

MS CAROLINE QUEST, MR PETER FARRIER,
MS MARGARET CUDMORE, MR STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

[Chairman Cont]

the revised IHA code of practice on patients' complaints. Particularly relevant is the IHA's quality assurance policy which requires all those in membership of the IHA to sign up to an independent accreditation body such as the King's Fund Health Quality Service or ISO 9000 series. Those standards are very compatible with the standards that private medical insurers, from my dealings with them, are looking for.

(*Ms Cudmore*) Another point is that most of these services are complementary to those that are being provided by local health authorities. There is a regular process of monitoring, both in terms of contract reviews but also in terms of patient reviews, for the quality of treatment and the sharing of information about outcome work. Whilst the Health Service may substitute as purchaser there is still a range of mechanisms that the purchaser/provider arrangement provides for us to monitor quality jointly.

412. Ms Quest has already pointed to some of the inconsistencies and problems, particularly in the 1984 Act. Do any of the witnesses have other problems with or concerns about the inconsistencies and difficulties currently facing the regulation of your specific area of provision?

(*Dr Harris*) I would not disagree with anything that has been said. I think Ms Quest has actually said the majority of it, but to reinforce the issue about the inspection under the 1984 Act, it is patchy and in some areas the health authorities have put in place experts in the area. In our own area for instance the health authority have a retired psychiatrist who works on their inspection team because they have a large number of psychiatric beds in their area. That is not uniform across the country. If you compare it to the expertise available to the Mental Health Act Commission when they come and do inspections, the two systems really do not compare at all.

(*Mr Page*) Listening to the debate as it has unfolded in this Committee and in the House, there is this issue about having a separate body for the independent sector, including acute medical, surgical and mental health and all the rest of it. We would like some further discussion with those relevant about whether mental health is more appropriately regulated within the mental health environment, hence our enthusiasm around the Mental Health Act Commission, than necessarily just with the whole of the rest of the independent sector. That is not something that anyone has finalised a view on, either within the independent sector or, as I understand it, within the Committee members. It is an area that needs some careful consideration.

413. You have a view that there are clear distinctions that mean that you should have some separate framework perhaps. Is that the broad picture?

(*Mr Page*) Yes.

(*Dr Harris*) Possibly a separate framework from, if you like, the ordinary nursing home sector. It is a long term care—

414. I think that we were talking more in terms of CHI and NICE, which was of course discussed this week, as some of you know, with the Health Bill.

(*Dr Harris*) Our view is that we think we should be involved with those because the feeling is that for many patients they move between the sectors and certainly within mental health that is the case. If you are going to have a regulatory and inspectorial system it is much better to have one that includes the whole area where patients will be treated.

(*Ms Quest*) If I might just add to that, it goes back to what I said about the significance and the size and the growth of the sector. The idea of an inspection is to maintain and improve quality standards and to share good practice which the NHS has had trouble with; we all have in mental health. It would be facilitated by having one body that is covering the whole spectrum. It is in the patients' interests that practice is shared across both sectors and lessons learned. As government in the process of implementing national regulation then it is an excellent opportunity to have shared practice.

Mr Lewis

415. There is a difference in a sense in that some people, maybe less so in the mental health services, choose to go to the private sector to receive treatment and care that is not available in the public sector. Do you not think that that makes a difference in terms of saying that there should be a uniform regulatory system?

(*Dr Harris*) No, I do not think it does make any difference. Particularly in the field of mental health care, you are dealing with an extremely vulnerable group of people and I think services do need regulation, they need protection if you like. I am not sure the differences in terms of the sorts of services they could purchase or they would obtain under the NHS are not really that great. There are very few services that are unique if you like to the independent sector. Ms Quest has already made the point that there are large areas of national provision that are provided by the independent sector: substance abuse treatment centres for instance, which are provided largely in the independent sector and many of them by voluntary sector organisations. I think the needs of the patients should be paramount and therefore I cannot see why there is an argument to have two separate regulatory services.

(*Ms Quest*) Codes of practice and, the checks and balances that are introduced by statutory regulatory bodies are all quite clear that treatment should be provided according to patients' needs, not from which sector they are being treated in or how they are being funded. Patients are treated according to need. I do not see that corporate governance makes a difference as far as regulation is concerned. The mentally ill, however their service is being funded, should be entitled to Government assurance that the treatment they are getting is being regulated but, crucially, to an equal standard.

Mr Walter

416. I would like to look at the role of CHI, the Commission for Health Improvement, or whether it has a role. The majority of the evidence that we have taken from the acute sector argues that it should have a regulatory role. Do you feel that that is specifically

15 April 1999]

MS CAROLINE QUEST, MR PETER FARRIER,
MS MARGARET CUDMORE, MR STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

[Mr Walter Cont]

appropriate to your sector or do you think the regional commissions looking at care standards would be more appropriate?

(Ms Cudmore) We have some concerns about the regional commissions which go back to the discussion about inconsistencies, particularly in services that are of a very specialist nature where the expertise perhaps might rest nationally rather than regionally. If those concerns can be addressed through the regional structure, then that is an improvement upon the 250 regulatory authorities that we have now and the inconsistencies there. I do not see that the role that CHI has and the role that the regional commissions have may necessarily be at odds with each other. There may be a place for both, but the main message that we want to put across is that we should try as best as possible in the specialist arenas to remove any variations in standards.

(Ms Quest) My understanding from Modernising Social Services in which the Commissions for Care Standards are discussed is that they are going to be orientated towards residential and domiciliary care, and that is quite different from acute mental health hospitals, which is really what many of the facilities in the sector are. Here we really need to focus on regulating clinical services and clinical standards and that I understand is exactly the role of CHI.

Julia Drown

417. Perhaps I could follow that up because we are pointing out here the distinctions concerning long term care and there is an issue there when you are trying to compare nursing homes with mental nursing homes. I wondered how you think that should be accommodated. Does that distinction need to be made much clearer? How would you cater for the elderly patients with mental infirmity rather than those with other problems? How would you wish to see this regulated?

(Dr Harris) Because we come from the large groups perhaps, we would all see a distinction between residential and nursing homes that provide long term care from what we would see as acute psychiatric hospitals, whether they are tertiary services providing medium secure care or acute psychiatric hospitals. We would see a distinction there. There clearly is an overlap where you have some long term residential care homes that cater for detained patients because sometimes they have to cater for detained patients as well, and it would be nice if there were a neat dividing line when in reality there is not. If we were to try and define it, one of the defining lines comes on the degree of medical input and the degree of nursing input, that the units we are talking about by and large have high levels of trained nursing staff and resident medical staff, and that is different if you like from the long term care sector where there are lower levels of trained nursing staff and they do not have resident medical staff. It is a simplistic way of defining the difference, but there is not a very neat way of having an absolute cut-off.

(Ms Cudmore) The issue for long term care is the distinction between residential care and nursing home care and the need for a single regulatory authority so that all the issues that were very well described in running social services do not occur as

people become frailer in their homes. There are different issues and therefore the single regulatory authority is very important for long term care.

418. So the general rule would be that the elderly persons' home which is caring for people with mental health problems would be in with other nursing homes?

(Dr Harris) Yes.

(Ms Quest) Under the Commission for Care Standards and where patients who have higher levels of need are being cared for, particularly clinical medical and nursing needs, that would fall under CHI. At this stage we would not want to rule out CHI and the Commission for Care Standards being mutually exclusive because after all I do not think any of us know too much about those two bodies at the moment. It is a discussion that needs to take place.

(Dr Harris) I think one should not differentiate just on the basis of age either because clearly there are many older people who have acute psychiatric problems as well. Indeed, my hospital has a number of long term elderly patients who have a lot of nursing and medical needs. They are if you like in hospital rather than in a nursing home. It is that distinction.

(Mr Page) In these debates I always find that younger people have similar problems with defining in which category they fit. They might be under the Children Act, registered by social services and inspected there, so if you have an adolescent in a mental health facility you have got another layer of inspection coming in with social services. Again I know it is one of the Committee's interests about making sure that the social services inspectorate and the regime there is also connected to the Health Service for the purposes of mental health regulation and also for adolescents in particular because there are a lot of overlaps in our sector. It needs careful consideration.

419. Perhaps I could ask a question about acute psychiatry. Do you accept that because people can be deprived of their liberty there is an extra reason for regulation in that sector to be particularly open, particularly visible? I wonder whether you think, if so, that that need is currently being met.

(Dr Harris) Our view is that in mental health care it clearly does need to be very open. It is quite clear that people who are informal sometimes can be deprived of their liberty when they are in hospital. Indeed, the Mental Health Act is written in that way. The important thing is to say that there is a group of very vulnerable people who are being treated and it is quite right that the whole sector, whether it is the statutory sector or the independent sector, needs to be extremely open about the way it cares for people. Things have become much more open—they always were reasonably open—certainly from the independent sector point of view. We have had open reporting since 1998 so that the health authorities when they have done their reports on the sector, those reports are available to the public. When the Mental Health Act Commission make visits to our facilities their reports are public reports and they are sent to the health authorities. I do believe that the whole sector has become much more open. I have no doubt that there could be more improvements, there

15 April 1999]

Ms CAROLINE QUEST, Mr PETER FARRIER,
Ms MARGARET CUDMORE, Mr STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

[Julia Drown Cont]

always can be, but there have been a lot of changes and I really do not believe that there is either a desire to be or a reality of being secretive about the way we care for people.

420. Those improvements that you mentioned, what improvements would they be?

(Dr Harris) You can always be more open about your inspections, you can be open about the quality standards. I have no doubt that if the regulation system is better it will be picking up on clinical governance issues as well in a way that it does not at the present time.

Chairman

421. In respect of the models that we are all exploring for future regulation and inspection, putting on one side the issue of people who are under statutory supervision of some kind, who are sectioned, do you see it as reasonable to envisage a system that would enable any particular patient who may move through different forms of provision within the independent sector with a variety of status in terms of the Mental Health Act to have a consistent process of inspection and regulation over and above or alongside the Mental Health Act Commission? Is it unreasonable to suggest that that might be achievable? It strikes me as rather odd that, depending on a patient's circumstances, they move from one regime to another to another. If they are sectioned that is an additional kind of qualification with the Mental Health Act Commission and, depending on how they end up in an environment, there is the purchaser's involvement in this. Do you feel it is reasonable to assume that we could achieve a consistent system that could follow a patient through these various stages regardless of their particular status?

(Ms Quest) Yes. I think that is what the Government is trying to do by introducing NICE and CHI. The two go together with NICE setting the standards. If you have clear standards and a national service framework as to how people, whatever their status, should be treated, then it becomes a lot easier to monitor their care and treatment against those standards, which is what CHI is all about. As far as the Mental Health Act Commission is concerned, it has a very specific role at the moment and it might be slightly unfair to judge it in terms of inspecting all aspects of mental health because it is there to watch over the rights of detained patients under the Act. It has a specific remit. I think the National Service Framework, NICE and CHI together could take us a long way towards that position where people can move through the system, through different statuses, through different institutions, and expect to receive a high quality standard of service.

(Mr Page) We are not saying, and perhaps it is one of Mr Lewis's questions in a sense, that that should be the absolute standard that everybody receives written down and you get A, B and C. We are saying it is like the kitemark or the standard to which you would expect everyone to aspire and if people then are able to get more than that or if their GP in particular within the Health Service or elsewhere thinks there is something additional that is required, that is available. My understanding of the National

Health Service frameworks within NICE and within CHI is that there will still be areas of discretion for clinicians because all medicine is organic and complex.

Mr Austin

422. In your written evidence you have talked about a treatment service that should be explicit and capable of systematic audit. You have spelt out the role of NICE and CHI in the setting of standards. Who should carry out the audit and who would be responsible within that health sphere for doing the monitoring? Would it be the Mental Health Commission or would it be CHI or some other body?

(Dr Harris) Our view at the moment is that it should be CHI. At the end of the day it does not matter. CHI is the body the Government is talking about as being the regulator for health provision and it would make sense from our perspective to have the same regulator, whether it is the statutory sector or the independent sector, and for psychiatry that could be delegated to the Mental Health Act Commission by enabling them to look at the conditions for informal patients as well as detained patients. It could go back to the Health Advisory Service. It could be delegated to another authority. At the end of the day it probably should be under the terms of CHI because that is the body that the Government is talking about having a regulatory function.

(Ms Quest) It might be very helpful and I think CHI will have the authority to be able to delegate or at least share its inspectoral role with other bodies, for example in overcoming the overlap that we talked about earlier between nursing homes and acute hospitals.

423. I was thinking as well about the position of those with learning disabilities or maybe brain injuries and whether they should have an inspectorate.

(Ms Quest) It would depend on the level of need.

(Dr Harris) At the moment people with learning disability and brain injury in a way come under the same sort of regulation as people with mental health problems, that if they are detained, and some of them are of course detained under the Mental Health Act, they are then regulated by the Commission. If they are not detained they come just under the registration of the 1984 Act. The issue for us is having a body that has the expertise to ensure that standards are met, that we have set standards and presumably one hopes the national service framework and NICE will come out with standards, and then we are audited by people who can do it against those standards, and if it is brain injury or learning disability that there will be people who have knowledge in this area.

(Ms Quest) Most people with learning disabilities however live in registered care homes because they do not have a mental illness and they are looking for a long term, homely environment and they do not need to be treated for a mental illness.

(Dr Harris) The majority are indeed living in the community.

15 April 1999]

MS CAROLINE QUEST, MR PETER FARRIER,
MS MARGARET CUDMORE, MR STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

Mr Lewis

424. Are there ways in which you think a modernised or new regulatory structure might end up leading to more of a partnership between regulator and provider?

(*Ms Quest*) That would be ideal but I think that in order for that to happen there has to be a will. That is probably the crucial aspect, that there is a willingness for there to be a partnership and that we would need to be included wherever possible in the planning of those regulatory bodies and to participate in them. I am thinking for example of NICE which is a special health authority. I would support the sector being given the opportunity to have somebody in their own right sit on the special health authority in the same way as providers from the NHS. As far as inspection is concerned through CHI, I do now know how it is going to work but as far as the independent quality assurance schemes go, like HAS 2000 or the King's Fund Health Quality Service, those people who are signed up participate in the inspections, so the independent sector goes and inspects NHS hospitals and people from the NHS come and inspect the independent sector and that way it is a partnership and you do get sharing of good practice and learning of lessons. If we could introduce all that into the new regulatory mechanisms it would enable partnership and it would be very good for patients.

(*Mr Farrier*) In the same way as some members of the Mental Health Act Commission of course work in the independent sector and that does help the cross-fertilisation of ideas and information.

(*Ms Cudmore*) It has to be in the patients' interests for it to be a supportive rather than a combative process.

425. Turning to the issue of the care programme approach, there are obviously a number of concerns about where care programmes break down or do not work. We hear a lot of consequences of that. What is your experience of the care programme approach on the grounds of what are the difficulties? What are your views? Is there a particular difficulty when a patient is placed outside of their area? Does that present particular problems? Is the care programme approach more likely to break down in those circumstances?

(*Mr Farrier*) The care programme approach was adopted fairly early on by the independent sector. The helpful thing about CPA is that it includes a number of other tools, including risk assessment, and does ensure compliance which is very important. From the last code of practice issued it is now a guiding principle, so we see that as particularly important in our work. With regard to the involvement of local referring authorities, the attendance is often mixed. In cases such as that, certainly our hospitals are advised to work with the Mental Health Act Commission and advise them where there are difficulties in developing the CPA, and the Commission is very helpful in making that very meaningful link with the local referring team. I should also say that we are taking the advantage in this important piece of work to have some research carried out right across about 400 patients with the King's College London Centre for Mental Health Service Development. Our hope is to publish the

results of its findings which includes the views of patients, carers and the authorities. With regard to distance, that is not always a problem. It is about commitment.

(*Dr Harris*) Certainly the whole sector believes that we should be complying with CPA. I do not think there has been any reluctance at all to adopt it as a procedure. If you were to look at the particular care programme approach, procedures used in independent hospitals, I think you would find it very rigorous, in many cases more so than in some statutory sector areas. You asked about how compliance should be monitored. Our view is that the Commission is the right body to do it. Certainly in the new code of practice that is made quite explicit and the commissioners, when they come round to do their inspections, are rigorous in looking at care plans and that they adhere to CPA. There is a difficulty sometimes with liaison with outside agencies. It is not for want of trying and I suspect with the outside agencies it is not for want of their wanting to do it. It is actually often a question of pressure of time.

426. There are difficulties. It would be wrong to give the impression that the care programme approach works smoothly every day and everything is okay. It is important to try and identify your experience of where the weaknesses are and where the system tends to break down.

(*Ms Cudmore*) I think people are trying to take extra steps to overcome the difficulties that are being experienced. We have an example where we have worked with quite a group of clinicians to try and make sure that there is an understanding of the process that occurs post in-patient treatment. There is a variety of mechanisms that are trying to be introduced where problems are experienced. To say that there are not problems would be wrong. There is the willingness to try to resolve the problems using a variety of different ways to overcome them when you realise that they are there.

427. I am wondering whether you often find that this commitment is made by external agencies as part of the care programme approach in terms of what their role is going to be and, where those agencies that are not able to fulfil the commitment and responsibility, whether that is a common experience or whether it is quite rare.

(*Dr Harris*) I think it is somewhere in between those. It is neither common nor rare. It does happen and I think it is because of pressure of circumstances. To be honest, having provided a tertiary level service in the NHS previously, the circumstances are very little different for tertiary NHS providers. Once you are one step further removed from the community team that liaison becomes more difficult; it does not become impossible, and you have to put more work into it. As a sector we all employ social workers, we employ community nurses, whose main role it is to try and make that liaison as good as possible. You can see there is an enormous difference in practice between different health authorities and social services departments. Some are extremely good at following up every patient that they have got placed outside the statutory sector. Some are less good. I do not know the reasons for that. It may be that some have set out deliberately to monitor everybody they

15 April 1999]

MS CAROLINE QUEST, MR PETER FARRIER,
MS MARGARET CUDMORE, MR STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

[Mr Lewis Cont]

have got contracted out. It may be that others have greater pressure of work. It would be wrong to say it is all wonderful and marvellous. It is not. But certainly we strive to try and make it as good as possible. Very often our teams have to go out to the local area to have case conferences rather than trying to bring people into the hospital as a way of trying to get round that.

428. Do you think there are sometimes perhaps cultural differences between the private sector and the public sector which get in the way of joint working?

(Dr Harris) No, I do not think it is a cultural issue. I think it is a pressure of work issue. I really do not believe it is a cultural issue.

(Ms Quest) I am sure you appreciate that most people working in the independent sector have also worked in the NHS. There is an enormous amount of crossover. At least a third of the placements in the sector are being funded by the NHS. The cultural differences are not so significant as to be an obstacle to continuity of care.

(Mr Farrier) We believe that if the Mental Health Act Commission could be given the necessary power we would not be averse to their having the statutory power to enforce compliance. We would welcome that.

Chairman

429. Mr Farrier, you were kind enough to arrange for us to visit Stockton Hall and I was very interested in the exchanges we had there with your colleagues and the staff and patients. It was most useful from the Committee's point of view. What struck me though was the extent to which you have in York a number of people who are from a considerable distance. Picking up a point that Ivan Lewis made about distance, it did worry me slightly, not in any way reflecting on the quality of care which was, as far as we could see, excellent, but in principle that you are caring for people such a long distance from where they originate. I would be interested in hearing a little bit more about the significance of that. I am not arguing that people from London cannot benefit from being in Yorkshire. I am the last person to say that. It just does worry me, and this may be an issue we explore in the second half of this session with some of the purchasers and regulators, so to speak, that moving people that distance has implications for the work that can be done in respect of rehabilitation and in respect of their contacts in the community. It appears to me to be against the philosophy of the Reed report in respect of trying to get people nearer the areas where they came from. What are your thoughts on that, the distance element, particularly picking up the point that local authorities do differ but distance must be a factor in the monitoring of quality of that provision.

(Mr Farrier) I think you are absolutely right, Chairman. I think a distance of 200 miles from London if you live in London is not a good thing. One of the first steps we took was to ensure that patients' relatives could make visits and we would support them financially in keeping contact with their families. That is an important facet of being committed that far away from home. I do not think

that it is such a problem now. The story has been reported on a number of times and for a number of years. Certainly with the increase of investment both by the National Health Service and by the independent sector the facilities are now more widely spread, thank God, around the country. That is coming down. The referral of course is the decision of the referring authority. As you rightly say, the authority would always refer to a service where it was going to get the quality of care for the patient that they saw as reasonable. The CPA programme of course helps keep that very important link with the local referring body. I have seen the number of referrals across the country within my own organisation dropping. Frankly, with the opening of a facility in Wales we see that as being very much part of the local service.

430. If we were in a situation where the patients that you have in York, for example, or some distance away from where they came from were not under section, were not covered by CPA and not covered by the Mental Health Act Commission, what would be the significance in respect of supervision by the purchaser? A good example of the picture that this Committee has picked up from looking at other areas is the placement of children and young people some distance from the areas where they come into care, that quite frankly they are often largely forgotten about and certainly not supervised in their placements in an appropriate way.

(Mr Farrier) One of the things that we have developed are the service level agreements with statutory referrals which actually cement very important conditions and obligations on behalf of the provider and the purchaser and reflect—and the Committee has a copy within our written evidence—the needs of the individual and the demands of the purchaser.

431. So over and above the statutory framework of the Mental Health Act Commission?

(Mr Farrier) Absolutely.

(Mr Page) We are talking here about a particular tertiary service, forensic psychiatry, and you will know that there is a debate in health care, as there is in cancer care and mental health care, about a particular specialty where you are always balancing between the quality of care, by having a volume and a level of specialist expertise focus, versus being local. Every Health Service manager has to make a decision about when to send someone some distance because they need that specialist care and when to keep them local. I know from talking to GPs and clinicians that this is sometimes quite agonising because you have got the family there which you would like to keep them close to, but they need the specialist expertise and it is just not available in your particular authority. That has to be an individual assessment that clinicians make and we try and work with those clinicians to make those decisions effective.

(Dr Harris) We probably have the largest number of adolescents in a health care setting on any one site. Ours do come literally from all over the United Kingdom. Our teams do work very hard at trying to keep up contact. It does not really matter whether they are detained or they are there under the terms of the Children Act. We make sure we keep in contact with the local referrers, with the social services, where

15 April 1999]

MS CAROLINE QUEST, MR PETER FARRIER,
MS MARGARET CUDMORE, MR STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

[Chairman Cont]

appropriate with the families because just occasionally it is not appropriate that the families are involved if the young person has been removed from the family in some way. It would not matter whether it was an independent sector service or a statutory service because clearly some young people services in the statutory sector are provided at a distance from home. You have to put a lot of work into keeping up those contacts. We try and do the same with our adult patients as well. You said "if they are not subject to CPA". Of course, technically they should all be subject to CPA.

(*Ms Cudmore*) I was going to make the same point, that clinicians—

432. I was thinking more in terms of strictly informal patients. I am trying to make a distinction.

(*Ms Cudmore*) With children I do not think you can make the distinction. I think it is always in the patient's interests for the links to be maintained and it is part of good clinical practice. If you had the clinical teams here before you they would be saying it is the most important thing pre-admission.

(*Dr Harris*) Can I just come back on the CPA issue? I just want to be clear: informal patients should be subject to CPA.

433. I understand that.

(*Ms Quest*) I think you were also talking about the role of the health authority in monitoring patients that are placed at some distance away. It is our experience that this is variable. Some HAs are very conscientious and take the time to come and make the visits and go through all the administration and so on, and some of them are not so diligent. Roughly I think one can say the greater the investment a health authority is making in a particular hospital the more likely it is to be very conscientious in regulating what is being provided, but there are situations where you get a quite reasonably sized unit, and I am thinking of one in drug and substance misuse services, where the patients are coming from lots of different health authorities, no one health authority having a particular incentive, because it is only sending one person, to regulate that unit heavily. That is why we have come to the conclusion that we need a national system of regulation which would sweep those problems away, hopefully.

Mr Gunnell

434. The Health Service Ombudsman: what role does he have and what role should he have in relation to your patients? Should his role be different for NHS patients?

(*Ms Cudmore*) Our view is that the Ombudsman should have a role across both sectors and that he would be the last point of independent review for the independent sector's complaints process just as for the state services. The sector has been quite good at trying to improve the management of complaints since the first code of practice was introduced in 1990. It has been revised again in 1999 and we have been working with the Royal Colleges to try and look at a variety of different types of complaints and the ways in which they can be regulated, including

complaints against medical staff. We see that the Ombudsman does have a role across NHS services as well as independent sector services.

(*Ms Quest*) As a final arbiter.

435. So it would make no difference where the patients came from or what their source of spending was?

(*Ms Quest*) I think that mentally ill patients, wherever they are being treated, should ultimately be assured that they have access to final arbitration and the NHS Ombudsman, for the reasons that again it is a way of sharing good practice and learning lessons. In view of the significance of the sector and the size lessons need to be learned across the sectors.

(*Dr Harris*) It is clearly for us as service providers as a sector to improve our own complaints procedure. We should be able to deal with the majority of complaints and resolve them to people's satisfaction within our own sector. That should be our aim. We want to monitor them and we want to eliminate those things that lead to complaints in the first place. Our view is that there has to be some final point of arbitration, and I think that our view is that the Health Service Ombudsman, the Commissioner, is the right person to do that.

436. You obviously all generally feel that the Ombudsman should have that role. Do you feel he does have that role?

(*Dr Harris*) He only has that role in relation to the NHS patients that we treat. Clearly any patient that is funded by the NHS in one of our facilities has the right to go through the NHS complaints procedure. A patient who is not funded by the NHS does not have that right and quite clearly they could, say, go to their general practitioner who has referred them in the first place and say, "I would like you to take my complaint to the Ombudsman", and they would have to say no, they cannot do it.

437. So that in general you would favour a change that would enable them to deal with all of them?

(*Dr Harris*) Yes.

Chairman

438. Do you feel the sanctions available to the Ombudsman are appropriate, sufficient, current?

(*Dr Harris*) The sanctions at present are just a name and shame sanction and one wonders whether that really is sufficient in general. I suspect the answer is probably no.

Mr Amess

439. Ms Quest touched on an interesting point about 20 minutes ago when she said about many people in the independent sector having worked for the NHS. You must be aware as independent providers that you are maligned in all sorts of ways, I happen to think quite unfairly. Could you give some detail, as you know you have been accused of pinching people from the NHS, precisely what specialist training you are able to give? The other general point is: could someone summarise what you feel your real contribution is in the independent sector to mental health services generally?

15 April 1999]

MS CAROLINE QUEST, MR PETER FARRIER,
MS MARGARET CUDMORE, MR STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

[Mr Amess Cont]

(*Ms Quest*) If I can take the contribution question and then pass it on to Dr Harris who is particularly involved in training issues, the major contribution is of course the size of the sector and the growth of the sector. It is not overall the size and volume of the services that we are providing but it is the development in the specialties, so that for example the independent sector is the majority provider of acquired brain injury services, it is the majority provider of drug and substance misuse services, it is the major provider of services for the elderly mentally ill. Over a third of new deal secure services are provided in the sector. Then there are the niche areas where it is growing very quickly and providing services for eating disorders and for children and adolescents. In those specialties it really is developing a locus of expertise and is becoming a major tertiary provider for the National Health Service. That is its contribution.

(*Dr Harris*) I do think that we have people who have developed expertise in a variety of areas in the independent sector that actually are not available in the statutory sector. Particularly if you look at things like the care of adolescents in mental health, we have some of the country's leading experts in the independent sector. In brain injury rehabilitation most of the expertise is in the independent sector. We have an obligation to be involved in training. We see ourselves as providing a national resource, the whole sector. We are involved in training. The whole sector is involved in training of all the specialties that work within mental health at every level. We would like to do more. We probably do not do as much as we could or should but we would like to do more and very often we find that we are frozen out by statutory bodies who stop us from taking trainees. It is not an unwillingness on our part to be involved. Having said that, there are certain areas where we provide a lot of training.

440. But can you give me any figures? You are accused of pinching people from the NHS service.

(*Dr Harris*) Can I challenge that concept first? I do not think we pinch anybody. One would have to say that we have staff who work in our facilities who are providing care to patients and those patients are citizens of the United Kingdom and they are entitled to that care. If they were not being treated in the independent sector I have no doubt they would be being treated in the statutory sector. The reality is that there is a shortage of staff. There is a shortage of trained, qualified, particularly nursing staff in other areas. It almost does not matter whether they are in the independent sector or the NHS because the patients are going to be the same numbers overall and they are going to need the same levels of care. People can choose to take their labour where they wish. In reality it is very unusual for people to come straight from their training into the independent sector. Most of them will have worked in the NHS for quite a long period of time before they choose then to move into the independent sector. We can give you training numbers if that would help. Mr Farrier perhaps can answer that one.

(*Mr Farrier*) May I just mention, Chairman, that with regard to the independent sector stealing nurses from the National Health Service, we survey very carefully through exit interviews what happens to the

nurses that leave our organisations, and it is very clear that of those that indicate where they are going to work in the future, between 35 and 40 per cent do return to the National Health Service. I think that is very good because people can take new ideas and new experiences for the betterment of patient care and whilst the nursing staff and other clinicians are moving through the sectors, it stops institutionalisation. We know very well when people get stuck into jobs and stay there for years and years that problems can occur. I welcome the chance for people to move freely around the sectors.

Chairman

441. Can I take a slightly different angle because Mr Amess and I do not have many disagreements but we are slightly at odds in our views on the private sector. I gather my own have been widely reported in the Health Service Journal today in very strong terms. He was talking about the issue of the private sector stealing nurses. I would not use the term "stealing patients", but one of the concerns I have, which clearly I reflected upon in my question to Mr Farrier about people having to move long distances, is the way in which the existence of your highly specialised service,—and I do not doubt the quality of the services and certainly the ones that we have seen have been of very high quality—as it is at some distance from where people actually live, actually obstructs the development of alternatives within the NHS of state services, of local authority services, in the area where people live. I will give you an example. We went, as Mr Farrier knows, to The Retreat at York. Again, I am sure all of us were very impressed by the quality of provision, by the caring attitudes, but it concerned me that when a large psychiatric hospital in my area was closed people were moved some 30 miles to The Retreat. The argument was at the time that it did not matter to these people who were long stay patients in an old former lunatic asylum that they were moving 30 miles. To me it did. There was an issue of principle there. In a sense I have a slightly different emphasis in my question from David Amess. I am more concerned your existence has retarded the development of services in the area in which patients live.

(*Ms Quest*) My colleague would like to say something.

442. I think we are getting slightly off our area of examination. This tends to happen with Mr Amess's questions for some reason.

(*Mr Page*) It is back to this clinical assessment thing. Those clinicians in that hospital you mentioned, your own hospital, have to make a decision about what they can best develop locally, what the patient's needs are, and also decisions about whether they can create something locally. I do not think it stymies the creation of that. One of the things that the Government is talking about is that public/private partnership. I would encourage your authority to be speaking to colleagues at The Retreat if they are not already about how that expertise can be brought more local, about the kind of set-up, about how the funding could work for patients. This is one of the things that has been difficult, to get that kind of dialogue going in the patient's interest. That

15 April 1999]

MS CAROLINE QUEST, MR PETER FARRIER,
MS MARGARET CUDMORE, MR STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

[Chairman Cont]

is what I would strongly encourage and support. If any health authority approached our organisations I think many of us here would welcome that kind of debate to see what we could do for patients locally.

(*Ms Quest*) May I just add to that. The reality is also that you cannot have a highly specialised unit in every town. There just is not the manpower, there is not the expertise, to be able to have specialised units on local street corners, and there are not the patients. One consultant needs a certain amount of patients in order to retain his own competence. I do think it is very much down to planning and this is exactly what we are saying here, that we would very much like to be routinely and formally included in planning at national level and at the local level. If we were to co-ordinate our planning, whether it is workforce planning through the education consortia, or whether it is health authority planning forums, then you would get greater partnership, and some of the problems that you have illustrated might be overcome.

(*Ms Cudmore*) It is part of the involvement in the planning process. There are examples where that works well. In fact in my own organisation, where there has been a sensible planning dialogue with the health authority, we have been able to act over a five-year period as a bridge to enable local services to be developed because they are in the patients' interests. The particular example is in child and adolescent services where there is a need for local services at one level, but there is also a need for specialist services geographically removed at a different level because of the incidence. We have been able to act as a bridge to enable less of a dependence on our own services and the establishment of investment and services in local facilities. There are probably as many examples where, when there is a good dialogue on planning, a better balance can be achieved where services are required to be local.

443. Can I put to Dr Harris about the specific situation in Northampton? My understanding was that when St Andrew's opened it had a significant impact upon the NHS provision within their area by the recruitment of consultants from the NHS service in that area. I am told that the service virtually collapsed as a result. That might be a biased view. It is not my view. It is somebody else's view, but there are implications presumably.

(*Dr Harris*) I think that is totally wrong, Chairman. You produced a very interesting example earlier with The Retreat because of course The Retreat has been in existence for over 200 years, long before the NHS. You say when St Andrew's opened it affected the local service. St Andrew's opened 160 years ago as Northampton County Lunatic Asylum and has been providing psychiatric services to Northamptonshire and elsewhere for a very long time.

444. Where did St Andrew's recruit its NHS consultants from?

(*Dr Harris*) We advertise in the British Medical Journal and—

445. So where do they come from?

(*Dr Harris*) They come from all over the place.

446. Were they from the local service?

(*Dr Harris*) Most of our consultants come from a considerable distance away. Some, like myself, commute considerable distances. You are referring to something that did happen about three years ago where a number of the local consultants—and this is where I wanted to make the point earlier because I think you are mistaking the relationship between the development of services in the independent sector and the difficulties the NHS have—in Northampton wanted to leave their trust because the services they were being asked to provide were so awful that they really were not happy working there any longer. They were choosing to leave altogether; some were wanting to leave health care, were looking to leave the field altogether; two of them were so exhausted because each of them had been doing three consultants' jobs for a period of two years because of failure to recruit. It was not that they could not recruit. They had not tried to recruit. They came to see if there were jobs available at St Andrew's at that time. That is what happened at that particular point in time. The reason the local services nearly collapsed is that the local services were not running themselves very effectively. I had only recently at that time moved myself from Nottingham. I was quite shocked because I had moved from what I saw as an extremely good NHS service to St Andrew's to be faced with what frankly was not a very good NHS service and not providing a very good service to the local citizens. If I can take the broad point though, Chairman, I do think that is mistaken. The NHS, for whatever reason, has chosen to withdraw from certain services. It has made a series of decisions based on some of the national policy decisions, some of the local decisions, to close hospitals, not to provide certain facilities, and the independent sector undoubtedly have taken up that challenge to provide some of those services. I do not believe it is the other way round, that the independent sector opening has drained the NHS. I really do not believe that.

Julia Drown

447. You have given there an example of an NHS Service not being up to scratch and the independent sector stepping in. You have expressed a willingness and a wish to be involved in planning of health services. Can you give us an example of where it has worked the other way round and perhaps an NHS facility has wanted to develop or to expand and a private sector establishment which was functioning perfectly well perhaps as a profitable and an economically viable unit, has agreed to close down in order for the NHS unit to expand?

(*Ms Cudmore*) There is the example I gave earlier where we worked with a health authority over a five year period to allow the level of investment required to provide local child and adolescent services. There was too great a dependence on in-patient care and crisis management in terms of child and adolescent admissions. We worked with the health authority with a known reduction in the requirement and dependency on the in-patient unit, which was a private one, to enable local services to come in to provide services which would reduce the need for admissions.

448. They were NHS services?

15 April 1999]

MS CAROLINE QUEST, MR PETER FARRIER,
MS MARGARET CUDMORE, MR STEPHEN PAGE
AND DR MICHAEL HARRIS

[Continued]

[Julia Drown Cont]

(*Ms Cudmore*) Yes. I think there are examples where these harmonies work.

(*Ms Quest*) I am not necessarily suggesting that you are, but it would be wrong to think that the independent mental health sector is in competition with the NHS if you like. Certainly from our perspective that is not the way we see it. We are here to provide mental health services, some of them greatly needed and not adequately provided within the National Health Service. That is our interest and we want to do that in partnership and in co-operation with one another, and if the sector in one area had to reduce its commitment because it was more appropriate to have on NHS Service, then, as the example shows, that would be the case. There is enough development in mental health services for everybody to play a part. Independent mental health care has some qualities that you do not get in the statutory services. Mentally ill people will often choose, if they have the choice, to be treated outside the statutory sector for the qualities that you can get in the independent services.

(*Dr Harris*) One of the difficulties in the statutory sector, and most if not all of us on this table have been involved in statutory sector services in trying to open them and plan them, is that there is very often perverse incentive, that if you plan to develop anew service in the NHS because you see a patient need, very often you are stopped from doing that because clearly the health authority is going to have to fund it in some way. They may say, "Okay, there may be a patient need but if you open the facility you are going to have to find the funds to pay for it, so we would actually rather you did not open the facility." I have to say in the independent sector if we see a patient need, if we have people ringing us up and saying, "Can you take this patient. We have got somebody in difficulties", we would try and develop the service. Perhaps for some of us that is why we moved from the NHS into the independent sector, in order to be able to do that.

Mr Austin

449. I wanted to revert to the vexed question of clinical freedom to make a judgement and the role of the Ombudsman. Do you feel that with the establishment of very clearly laid down care and

treatment standards the power of the Ombudsman will be enhanced in terms of his investigative powers? Also, do you feel that because there will be clearly laid down care and treatment standards which will be capable of audit and monitoring elsewhere, this is likely to lead to an increase or a decrease in demands on the Ombudsman?

(*Dr Harris*) I think we are waiting with interest the national service framework in psychiatry. Undoubtedly all clinicians working in psychiatry are going to have to work within guidelines. Clearly that is for adults with mental health difficulties, not for young people. I suppose ultimately if you have a new set of standards it may mean more work for the Ombudsman. One would hope that actually it would mean that hospitals would be trying to adhere to the standards that are set and that, with proper regulation, it should not be getting to the point where people are wanting to go to the Ombudsman to complain.

(*Ms Quest*) Also, all hospitals should aim to have a complaints procedure that should be able to resolve complaints, whether through mediation or, as the IHA is developing through independent arbitration, before a complaint actually gets to the NHS Ombudsman, so one would hope that those procedures would be of that quality.

450. Are there any other points any of my colleagues want to raise? Are there any points our witnesses want to add? Any issues that we have not touched on that you feel we might have done before we conclude this part of the session?

(*Ms Quest*) Chairman, I would just like to reiterate that we firmly believe that mentally ill people in whichever sector they are being treated should be entitled to Government assurance of equal standards of regulation.

Chairman: Can I thank you all for the very helpful evidence and again for your written contributions and, Mr Farrier, to you and your colleagues for allowing us to visit one of your establishments which was most useful. We are very grateful to you for your co-operation with this inquiry. Please feel free to remain for the rest of this session.

15 April 1999]

[Continued]

Memorandum by the Mental Health Act Commission

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 94)

INTRODUCTION

This memorandum contains a description of the remit and responsibilities of the Mental Health Act Commission, how the Commission pursues these in relation to mental nursing homes within the current regulatory framework and some of the challenges faced by some nursing homes in implementing the Mental Health Act 1983.

The Commission acknowledges the Government's proposals to improve the current regulatory framework set out in the White Paper — *Modernising Social Services*.

GENERAL ROLE OF THE COMMISSION

The main role of the Commission, which is a Special Health Authority, is to keep under review the operation of the Mental Health Act 1983 (the Act) as it relates to the detention of patients, or to patients liable to be detained, under the Act in England or Wales. In pursuit of that role the Commission:

- visits and meets detained patients in private. To this end all hospitals and registered nursing homes providing care and treatment for patients detained under the Mental Health Act are visited on average twice each year;
- inspects the records relating to any patient who is or has been detained;
- meets with representatives of Social Services Departments at least every two years, to discuss their responsibilities under the Act;
- investigates complaints that fall within the Commission's complaints remit;
- monitors the operation of the Consent to Treatment safeguards set out in Part IV of the Act and appoints doctors to give Second Opinions;
- publishes a biennial report that is laid before Parliament;
- monitors the operation of the Mental Health Act Code of Practice.

In addition the Commission is encouraged by the Secretary of State to advise on policy matters that fall within the Commission's remit.

The Commission's role is visitorial and only to a limited extent is to be able to act as an "inspectorate". This was acknowledged in the report of the Fallon Inquiry (*Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*. The Stationery Office, 1999), which stated that "at present it [the Commission] has neither the resources nor the statutory remit to undertake detailed inspections". The Commission does, however, comment on environmental standards and the extent to which the guidance in the Mental Health Act Code of Practice is observed. The Code is the Commission's primary source of standards.

MENTAL NURSING HOMES AND THE MENTAL HEALTH ACT

Under the Registered Homes Act 1984, Health Authorities register and inspect nursing homes on behalf of the Secretary of State. Mental nursing homes must be separately registered and may only detain patients under the Mental Health Act if specifically registered to do so. Such establishments must comply with all the provisions of the Mental Health Act.

The Commission has a statutory duty to visit detained patients in registered mental nursing homes. The total number of beds in the independent sector for those with mental health problems has increased significantly over recent years and are situated in facilities which range from large hospitals providing medium-secure care to small establishments where there may only be one or two patients detained under the Act. The number of smaller establishments appears to be increasing. The Commission currently visits annually some 135 mental nursing homes registered to receive detained patients. The Commission is usually notified of new registrations by the relevant registering Health Authority. Sometimes this does not occur and there can be a delay in the Commission undertaking its first visit.

To assist all those with registration responsibilities the Commission issued Practice Note 5 in July 1996 (which is attached at Annex A). This is currently being reviewed in the light of experience and comments received. Many registering authorities are developing good practice and now issue, along with Guidance Note 5, their own guidance/standards for registered homes caring for detained patients.

During each visit, Commissioners meet with those detained patients who have asked to see them, make contact with some who have not, check legal documentation and observe compliance with the Code of Practice. At the end of the visit, visiting Commissioners ordinarily provide a verbal feedback of the main

*15 April 1999]**[Continued]*

points arising from the visit and within five weeks the nursing home will receive a full written report. The home is invited to respond and this generally occurs without reminder. A copy of the Commission's report is also sent to the relevant registering Health Authority and the respective regional office of the NHS Executive.

Apart from rights of entry and access to detained patients' records, the Commission does not have any powers to direct services, for example, to remedy deficiencies identified on visits. Ordinarily, these are put right following identification, especially those deficiencies that relate to the implementation of the Act itself. Where this is not the case or their seriousness warrants further action the Commission seeks to involve the registration authority in addressing the issue. Overall the registration authorities welcome the Commission's involvement and co-operate in pursuing such matters.

It is the Commission's experience that larger mental nursing homes which are registered to receive detained patients and which provide care on a regular basis to significant numbers of such patients generally implement the Mental Health Act to the same standard as NHS hospitals. The Commission's concerns in relation to the implementation of the Act in the independent sector focus on some smaller nursing homes, especially those who do not regularly provide care and treatment for such patients.

MENTAL NURSING HOMES AND THE MENTAL HEALTH ACT—SOME PROBLEMS

Mental nursing homes registered to receive patients detained under the Mental Health Act have, as far as the Act is concerned, the same status as NHS hospitals providing care and treatment for detained patients and are subject to the same onerous legal requirements. Many smaller nursing homes registered to receive detained patients, especially those who only occasionally provide care for such patients, often seem unaware of the full extent of the Act's requirements.

The Mental Health Act imposes important obligations on the "Manager" (for registered mental nursing homes these are "the person or persons registered in respect of the Home" under the Registered Homes Act 1984) and they have responsibilities in relation to admission, discharge, and provision of information for health and local authorities, information (including information about rights) for patients and relatives and access to Mental Health Review Tribunals. These are helpfully summarised in Chapter 22 of the Code of Practice (which is attached at Annex B).¹ These responsibilities are central to the proper and effective implementation of the Mental Health Act and not infrequently, the Commission's initial visit to some newly registered mental nursing homes (which on occasion, can take place some time after registration) reveal only a rudimentary understanding of the Act and its implications.

The implementation of the Mental Health Act can also present other challenges for some mental nursing homes. For example, every detained patient should have a "Responsible Medical Officer" (RMO), defined in the Mental Health Act as the doctor "in charge of the patient's treatment" and described in the Memorandum to the Mental Health Act (Department of Health and Welsh Office. The Stationery Office (1998)) in relation to hospital patients as "a consultant who is in charge in the sense that he/she is not responsible or answerable for the patient's treatment to any other doctors". This latter advice is good practice and not a legal requirement. In the Commission's experience there are occasions, especially in relation to some smaller nursing homes, where a detained patient's RMO is not a consultant, but, for example, a local GP. The problem is not necessarily that one sort of doctor is better or worse than another at undertaking the RMO's responsibilities, but that frequently such doctors work part-time and are the only medical practitioner employed by the nursing home.

The RMO has important statutory obligations including the power to grant leave of absence, to make a report preventing discharge by a patient's Nearest Relative, to make a report which reviews the authority to detain and, in relation to certain patients, to provide statutory reports to the Home Secretary. The RMO also plays a key role in ensuring that the provisions of Part IV of the Mental Health Act, which set out the consent to treatment safeguards, are implemented.

In its last Biennial Report (Mental Health Act Commission. Seventh Biennial Report 1995–1997. HMSO (1997)) the Commission devoted one section to registered mental nursing homes and a copy extract is attached at Annex C.¹

CONCLUSION

A number of the difficulties with implementing the Mental Health Act in some mental nursing homes referred to in this memoranda primarily stem from the application of the Act's provisions in different health care settings than those envisaged when the Act came into force. Hopefully such problems will be considered during the current review of the Mental Health Act.

¹ Annexes not printed.

15 April 1999]

[Continued

The Commission would like to recommend that, within the context of the current regulatory framework, attention be paid to ensuring that the ability to comply with the requirements of the Mental Health Act receive greater prominence in the registration requirements, so as to ensure that adequate procedures are in place at the time of registration. The Commission has suggested, in relation to the Registered Homes Act 1984, that consideration be given to amending the regulations so that registering Health Authorities can withhold or withdraw registration from mental nursing homes to admit detained patients on the ground of lack of compliance with Mental Health Act procedures.

April 1999

Memorandum by MIND (National Association for Mental Health)

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 85)

INTRODUCTION

1. MIND is the leading mental health charity in England and Wales. It raises public awareness of mental health issues and works for the right of people diagnosed as mentally ill to lead an active and valued life in the community.

2. Our evidence to this committee is concerned solely with private and independent healthcare in the mental health field. The focus is on psychiatric hospitals and mental nursing homes. We are not commenting on issues surrounding the use of psychotropic medication in general nursing homes. Neither do we cover regulation of private counsellors and therapists.

SOME FACTS AND FIGURES

3. There has been a large increase in the proportion of beds for mental illness available in the independent sector over the last 10 to 15 years. According to the 1995–96 NHS Annual Report as reported in the Mental Health Act Commission's Seventh Biennial report¹ in 1983 there were 81,786 (97.2 per cent) mental illness beds in NHS facilities in England and Wales and 2,394 (2.8 per cent) in independent facilities. By 1994–95 the figures were 41,827 (63.3 per cent) in NHS facilities and 24,190 (36.7 per cent) in independent facilities. The number of formal admissions (ie, under the Mental Health Act) to private nursing homes increased from 430 in 1990–91 to 790 in 1995–96².

4. Within the independent sector there are two main types of provider:

- (a) Not for profit/charitable providers such as The Retreat, Cheadle Royal and St Andrew's;
- (b) For profit institutions which are often part of large groups. Partnerships in Care (PIC) for example run a number of relatively large institutions including Kneesworth House (159 bed hospital in Hertfordshire), Stockton Hall (106 bed hospital near York), Llanarth Court (64 bed hospital in Gwent) and Redford Lodge (60 bed unit in North London).

5. The types of institution range from large hospitals to small establishments with only a handful of patients but fall into three main categories:

- (a) Acute and substance dependency. An example here would be the Priory in Roehampton;
- (b) Special care mainly for those who are difficult to place, with behaviour problems or brain injuries. This includes a number of medium secure facilities such as three PIC hospitals listed above. Between them these three hospitals and St Andrew's accounted for about 300 of the 790 Mental Health Act admissions to the private sector in 1995–96;
- (c) Mixed care. Mainly charitable hospitals covering acute, medium and long-term patients. An example here would be St Andrew's in Northampton.

6. There are also three types of funding source for this sector:

- (a) Self-funding;
- (b) Funded by health insurance;
- (c) Funded by Regional and District Health Authorities.

7. Special care is largely funded by the third of these routes and such funding also provides a smaller but significant contribution to other types of care. At the Priory in Roehampton for example 20 per cent of patients come via the NHS. Insurance provision accounts for about 40 per cent of patients in the sector³. The

¹ The Mental Health Act Commission (1997) *Seventh Biennial report 1995–97*. Norwich, The Stationery Office.

² Department of Health (1997) *In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation 1990–91 to 1995–96*. Statistical Bulletin 1997/4.

³ John Henderson, Medical Director, St Andrew's Hospital, in *Psychiatric bulletin* (1990) 14 page 479.

15 April 1999]

[Continued

role of insurance is currently less significant in mental than physical health because of the exclusion of mental health from many insurance policies although this may change with the coming into force in October 1999 of section 21 of the Disability Discrimination Act requiring service providers such as insurers to end practices and procedures which make it impossible or unreasonably difficult for disabled people to use their services.

THE EXISTING REGULATORY FRAMEWORK

8. Private psychiatric hospitals are registered as mental nursing homes, so are subject to the regulations governing this sector. Under Part II of the Registered Homes Act 1984 Health Authorities must inspect each hospital at least twice a year and be satisfied that the statutory requirements and any local conditions for registration are being met. Inspection may be out of hours and unannounced. It may include an interview in private with any patient either for the purpose of investigating any complaint made by them or on their behalf or where there is reasonable cause to believe that the patient is not receiving proper care. Health authorities have the power to cancel registration if a hospital fails to comply with any of the statutory requirements or local conditions or to vary the conditions of registration.

9. In addition relevant powers exist under the Mental Health Act 1983. Under section 120 the Mental Health Act Commission has power to visit and interview, in private, patients who are detained under that Act in mental nursing homes and to investigate complaints. Under section 115 an approved social worker of the local social services authority may enter and inspect a mental nursing home if he/she has reasonable cause to believe that a mentally disordered patient is not under proper care.

CAUSE FOR CONCERN

10. There are reasons to be concerned about standards of care in the private sector.

- In June 1991 AMI Healthcare announced that it was to close Langton House—an adolescent unit in Northampton—following criticisms from the Mental Health Act Commission concerning the use of drugs and solitary confinement;
- An audit of Kneesworth hospital carried out by City and Hackney Health Authority at the end of 1994 following the deaths of four patients in five months found that the hospital “adopted a ‘factory’ approach to deeply disturbed patients, using ‘custodial’ techniques rather than the individual treatment regimes in the NHS;”⁴
- In their Seventh Biennial Report the Mental Health Act Commission expressed continuing concern over the comparatively large number of complaints received from private sector establishments.⁵

SPECIFIC ISSUES

11. Specific issues which MIND would identify are as follows:

Registration and compliance with the Mental Health Act

12. Registered mental nursing homes must comply with all the provisions of the Mental Health Act in respect of detained patients. In order that the legality of detention and compulsory treatment can be monitored it is essential that proper records are kept. Most NHS hospitals employ Mental Health Act monitoring officers for this purpose. Unfortunately proper records are not always available in the private sector as highlighted by the Mental Health Act Commission.⁶ Examples of problems noted in their most recent biennial report are:

- Failure to record correctly the formal admission and receipt of medical recommendations;
- Failure to complete the form recording consent to treatment;
- Failure to complete second opinion forms authorising treatment.

They also note patchy adherence to the legal duty to provide information to patients and ensure that it is understood sufficiently.

13. MIND would strongly support the Commission’s recommendation that the regulations of the Registered Homes Act 1984 be amended so that registering authorities can withhold or withdraw registration from Mental Nursing homes to admit detained patients on the grounds of lack of compliance with Mental Health Act procedures.

⁴ *Care fears after deaths in ‘factory’ hospital.* *The Observer* 8 January 1995.

⁵ Mental Health Act Commission op cit page 122.

⁶ Op Cit pages 74 to 76.

*15 April 1999]**[Continued]*

14. Where medium secure or other services likely to deal with a high proportion of detained patients are being developed in the independent sector MIND would suggest that registration authorities should be required to consult the Mental Health Act Commission (MHAC) prior to registration. Such involvement has in the past proved helpful particularly in relation to staffing levels.⁷

Advocacy

15. The four large independent hospitals referred to above (Kneesworth, St Andrew's, Stockton Hall and Llanarth Court) have now developed advocacy services for patients and this is a very welcome development which MIND would like to see expanded throughout the sector. We understand however that at least one of the hospitals decision as to whether to allow an advocate on to a ward or to attend care planning meetings or Tribunals is a matter for the ward's responsible medical officer. This has in one case led to the advocate being excluded from two of the six wards in the hospital. This is clearly unsatisfactory. We believe that what is required is a service protocol on advocacy for the whole hospital thus removing the decision from individual medical officers. We would also like to see group advocacy schemes in the form of patients' councils at the larger establishments so that users can have an input to service development, planning and delivery. Requirements relating to advocacy could be built in to service requirements by the funding agencies.

Standards of care

16. MIND would not wish to suggest that private mental health care is always of a low standard. The sector undoubtedly makes an important contribution especially in the medium secure sector often to a high standard. We do have concerns however about the best mechanism for ensuring consistently high standards across the board.

17. Many of those referred to private hospitals by the NHS are well outside the area of their own health/local authority and this means that inspection visits by funding authorities can be rare or non-existent. It can be a case of "out of sight, out of mind". We believe that requirements on funders in this respect should be tightened up. As part of this process we would also like to see much greater use being made of service agreements between funders and providers. These would be able to specify a range of quality issues relating to staffing levels, training, appropriate care for black and ethnic minority patients and issues of concern such as use of seclusion and ward environments (including single sex provision). These agreements could be used as a way of ensuring greater compliance with the type of service guidelines which apply in the NHS including those being developed through the new National Service Framework. They could also provide the basis for monitoring visits and could be available to advocacy services who could draw the attention of funders to issues of concern.

Complaints

18. Concern about the complaints system for detained patients in Registered Mental Nursing Homes has been expressed by the Mental Health Act Commission in both of their last two biennial reports.⁸ These concerns have centred on:

- The large number of complaints from this sector;
- The lack of managerial acknowledgement of some justification for patient dissatisfaction;
- The lack of independence in the complaint procedures.

19. MIND would endorse these concerns together with the Commission's recommendation in its sixth biennial report that current complaint policies in the sector should be reviewed in line with NHS practice. Again the use of service agreements suggested above would seem to be a way of improving practice in this area.

20. MIND also has concerns about the complete lack of complaints procedures in some mental nursing homes, which leaves voluntary patients with no redress. We would refer here to the points made in the written evidence to the Committee by Mrs Elaine Isaacs of Manchester which we fully endorse. People with complaints against health care providers in whatever sector need to be heard and have their concerns taken seriously and have confidence that steps will be taken to prevent a similar thing happening again.

February 1999

⁷ Mental Health Act Commission Sixth Biennial Report 1993–1995 (1995) HMSO.

⁸ Sixth Biennial Report pages 38–39. Seventh Biennial Report page 122.

*15 April 1999]**[Continued]***Memorandum by Royal College of Psychiatrists****THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTH CARE (PM 71)**

Thank you for inviting the Royal College of Psychiatrists to comment on this increasingly vital aspect of healthcare. This submission is based on general debate within the College's Executive and Finance Committee, on the experience of members of the College's liaison committee with the Independent Healthcare Association; and on the specific observations of those College Faculties and Sections representing the sub-specialties most involved.

1. THE CURRENT SITUATION

1.1 Whilst most psychiatric care still takes place within the National Health Service, the independent sector has taken on increasing responsibilities. The sector provides approximately 20 per cent of acute psychiatric care, 81 per cent of all brain injury services, 30 per cent of medium secure care, 44 per cent of residential care for learning disability and the majority of residential care for those needing treatment for substance misuse and of the elderly. It employs, either full or part time, 11.5 per cent of all consultant psychiatrists in post. Including those with admitting rights to the independent sector, approximately 25 per cent of all consultant psychiatrists have an involvement with it of some kind.

1.2 The treatment of people with mental health disorders can take place in a number of different settings within the independent sector. These may include outpatient clinics, acute in-patient units, medium secure units, 24-hour nursed care, residential social care, nursing homes, and independent psychotherapy and counselling practice.

1.3 These are subject to a variety of inspection and regulation procedures. Inpatient units are effectively independent psychiatric hospitals although regulated as "nursing homes". These have regular inspections from the Mental Health Act Commission and the nursing homes inspectors from the health authority under which they are registered. Those units that take NHS patients (the majority) are also subject to inspection from the purchasing authorities. The minority that have psychiatric training posts are subject to inspection by the Royal College of Psychiatrists.

Twenty-four-hour nursed care units and nursing homes are subject to inspection by the registering health authorities.

Residential social care, which includes psychiatric rehabilitation hostels, units for the treatment and rehabilitation of those with substance abuse problems, units for those with learning disability, brain injury or the elderly, is subject to inspection by Local Authority social services departments.

Those practising independently in outpatient settings or in independent psychotherapy or counselling practice are subject only to the regulation of their professional registration authority where there is one (for example the General Medical Council for medical practitioners).

1.4 This variety leads to a number of concerns:

- (i) The staff working in the less well regulated units, particularly the social care units, may not be appropriately trained or qualified for the role they take;
- (ii) There are concerns about the assessment procedures before admission to the units;
- (iii) There is a general concern about the effectiveness of monitoring of social care, nursing homes and independent practice;
- (iv) There is concern about equity of access across the country;
- (v) There is concern about local and national planning, with the independent sector being excluded from statutory sector planning;
- (vi) There is concern about manpower planning for the same reasons.

2. RECOMMENDATIONS:

2.1 The Royal College of Psychiatrists makes the following general recommendations:

- (i) External regulation, inspection and monitoring of all residential units, using multi-disciplinary inspection teams with skills appropriate to the area being inspected;
- (ii) Standards of training and manpower for all staff in the independent sector, that are equal to those in the NHS;
- (iii) National planning involving the independent sector and ensuring equity of access;
- (iv) National standards for the assessment, care and treatment of people entering residential facilities;
- (v) National protocols for discharge from care;

15 April 1999]

[Continued

- (vi) Registration of out-patient practitioners with an appropriate, national professional body and regulation of their work to national standards.

2.2 Detailed comments not covered above:

(i) Psychotherapy Faculty:

Registration of practitioners should be with either the UK Council for Psychotherapy or the British Confederation of Psychotherapists. The Specialist training Authority's Certificate of Completion of Specialist Training should be the "gold standard" for clinical practice. The determination of length of treatment based on an ICD 10 diagnosis, as in so-called "managed care", is based on "pseudo-science" rather than true evidence.

(ii) Rehabilitation and Social Psychiatry Section:

Residential social care units should be governed by a "fit for purpose" standard of inspection undertaken by NHS professionals. The inspection teams should have a right of access, including for night visits. Staff training should be at least to NVQ level 3, with the head of unit to higher standards.

(iii) Faculty of Psychiatry in Old Age:

Admission to residential placement should only follow full assessment and treatment of remediable conditions and should be regularly reviewed in liaison with external specialist teams. All aspects of care should be monitored, from general standards of accommodation to specific treatments such as psychotropic medication. There should be specialist General Practitioners for residential and nursing homes. Residents should be grouped according to care needs rather than diagnosis and assessed by a national "dependency scoring" system. Weaknesses in current mental health legislation as it applies to the elderly need to be identified and resolved.

(iv) Addiction Faculty:

The Standing Conference on Drug Abuse (SCODA) lists 100 residential treatment units, offering a total of 1,700 places for an age range of 11 years upwards. There should be better strategic planning across the whole sector with agreed criteria for referral pathways and funding. Programmes of treatment should be evidence-based and after-care required to the same standard as the Care Programme Approach in the NHS. In a speciality that carries significant risks of morbidity and mortality, the medical components of detoxification services need close monitoring.

Examination of Witnesses

MR MARTIN BROWN, Health Services Directorate, Department of Health, was further examined, DR TIM JERRAM, Chairman, Legal and Ethical Committee, Mental Health Act Commission, MS MARGARET PEDLER, Head, Legal and Policy Development, MIND and DR ROB JONES, Head of Section of Old Age Psychiatry Nottingham University Medical School and representing Royal College of Psychiatrists, were examined.

Chairman

451. Could I welcome our second group of witnesses. Thank you for coming along and also for the written evidence. I wonder if I could briefly ask you each to introduce yourselves to the Committee. Dr Jones?

(Dr Jones) Dr Rob Jones, Head of Section of Old Age Psychiatry at the University of Nottingham but representing the Royal College of Psychiatrists. Obviously speaking from an old age psychiatry perspective but hopefully I can give you some help wherever CHI might need to roam.

(Ms Pedler) My name is Margaret Pedler and I am Head of Legal and Policy Development at the mental health charity, MIND.

(Dr Jerram) My name is Tim Jerram. I am here representing the Mental Health Act Commission where I am Chairman of their Legal and Ethical Committee.

(Mr Brown) Martin Brown, Head of Mental Health and Learning Disabilities in the NHS Executive.

452. We are likely to ask specific questions to individual witnesses. Can I ask please feel free, if you are not being asked a direct question and want to contribute, to catch my eye. We would like to hear your views. Can I begin by asking Ms Pedler one or two questions. Presumably you were here for the previous session and some of the discussions we had.

(Ms Pedler) Yes, some of it.

453. I wonder what your general thoughts are on the extensive use of an independent regime within mental health services compared with that within acute medical services elsewhere. You heard some of the exchanges that we had about the implications of the use of the independent sector, I wonder what your broad thoughts are and MIND's thoughts are on this general issue, the extent to which compared to general medicine certainly psychiatry and mental health and similar areas are clearly using the independent sector far more than other areas?

(Ms Pedler) Yes. I think it is quite a complex picture. There is quite a lot of different ways in which people are in the independent sector for mental health services. Obviously there is quite a large proportion of people who are funded by the NHS and others who are funded through insurance or who

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Chairman Cont]

are just basic private paying patients. I think we probably have more contact with the NHS funded patients than we do with other groups within the sector. I suppose the perspective that we are coming from really is that we want to see high quality services for users of mental health services and so if the services that people need are not currently available within the NHS then obviously we would want use to be made of the independent sector. If that is the only way people can get specialist services that they need then we would be happy that that happened. I think also we are concerned about people being a long way from home, the point you were making earlier, and the fact that sometimes people lose touch, certainly when it comes to something like discharge planning, social workers from the referring area do not often go to the meetings and it can be more difficult for people to then come back to effective community care in their own area. I think that certainly we would welcome the development of more specialist facilities within the NHS itself.

454. Can I ask for your general thoughts on the current regime which is extremely confusing to anybody looking at it from outside. There are all sorts of inconsistencies, depending on the patient, depending on where they are geographically, who they are placed by. What are your general views on the current arrangements and what are your thoughts on some of the points that were perhaps made in the previous session about how the future might be addressed?

(*Ms Pedler*) I only came in towards the end of the previous session.

455. You may not have heard some of the points.

(*Ms Pedler*) I did not necessarily hear all of the points. I think that at the moment we feel that for some people who are within the private sector, there is confusion, for example, about issues like access to complaints procedures, for example. I know it has been said very clearly in evidence to this Committee that an NHS patient who happens to be in the independent sector has access to the NHS complaints procedure but I do not think that is necessarily clear to people who themselves are being treated within the independent sector. I think that all needs sorting out. I think also that there is a lot more scope for greater use of service agreements between funders and providers. There was discussion earlier about where there is a funder who has a large number of people in one hospital, and they have quite a lot of incentive to get involved in planning in that hospital, but where you have got a hospital where there is only one or two from a large range of areas it is much less clear who is getting involved in regulating the hospital and inspecting the hospital. I think we see that as an area where there needs to be greater tightening up, perhaps with more requirements on funders to use service agreements which could bring in NHS service standards around from the National Institute for Clinical Excellence and other bodies that are being set up at the moment.

456. This was the point that was made by previous witnesses. They wanted to see the independent sector included—I think that was the general consensus—within the proposed CHI and NICE arrangements.

Is that something your own organisation would support or is it maybe something you have not addressed yet?

(*Ms Pedler*) Yes. My understanding anyway is that for the patients who are funded by the NHS they will come within the CHI and the NICE framework in any event. I suppose we would want to see proper safeguards for people who are receiving mental health services, whatever source they were funded from, but obviously then that raises the issue of whether there should be some sort of levy on the private sector to fund the use they were making of the state funded regulatory body.

Julia Drown

457. There does seem to be quite a lot of confusion about the different responsibilities of primary care, the acute sector and the independent sector. This is particularly a question for MIND; whether you think there is some confusion there and, if so, what proposals you might have to overcome that confusion?

(*Ms Pedler*) I mentioned already the problem about complaints procedures and which complaints procedures people have access to. That is one area where we think there is an issue around people not being clear to whom they should complain. I am not quite sure really I would go so far as saying there is the confusion of responsibility. I suppose there are gaps in NHS services at the moment that are being filled by the independent sector, particularly in special care and medium security for example is one particular area. I do not know that I would describe it as confusion.

458. How commonly would you come across cases where a person needed some sort of help, they go to primary care and primary care would say: "No, your needs are greater than we can deal with", they then try and get into acute hospital and they say: "You are not severe enough for us to deal with you" and they fall in the middle?

(*Ms Pedler*) I think that does happen. I do not have any figures for it. I would hope that if that happened then the person would be able to go back to the primary care and say: "Look, this has not succeeded but I do still need some help" and then there would have to be some recognition that they need some help in another way. I would hope that it would not happen that that person was left without anything in those circumstances. I would see it as the responsibility going back to the primary carer.

459. It is not a frequent occurrence?

(*Ms Pedler*) Not that I am aware of.

Mr Austin

460. You may know that this Committee, looking at other areas of service provision, has been quite enthusiastic about the role of advocacy?

(*Ms Pedler*) Yes.

461. We know that in terms of psychiatry hospitals advocacy workers are available in some hospitals. Perhaps you would like to say something about your view of their training, their remit and their role and

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued

[Mr Austin Cont]

also about accessibility? In your written evidence you suggested that people may be denied access to advocacy at certain levels in the structure?

(Ms Pedler) Yes. I think we attach very high importance to the availability of independent advocacy in the mental health sector. As part of the evidence that we were preparing for the review of the Mental Health Act, which the Government are currently carrying out, we did a survey of the various MIND networks. One of the issues we asked about was advocacy and we asked whether people supported a right to independent advocacy, particularly at any time when the use of compulsion powers were being considered. 95 per cent of the respondents to the questionnaire said that was something they wanted to be available. I think when we talk about advocacy, we are talking about two different types. We are talking partly about group advocacy schemes, like patients' counsels that are being made available in psychiatric hospitals or units so that people who are there are able to have some influence over the day to day running or development of the unit and we would like to see that happen as a matter of course, as it does in Holland. Then there is the question of individual advocacy. What we think is important are two things. We think it is important that the advocate is independent of the service provider because otherwise there may be conflicts of interest, or certainly the person receiving the advocacy service may feel that they are not necessarily getting independent advice. Also we think it is important that there is a code of practice which makes it clear that the advocate is entitled to be at meetings or to attend discussions about treatment or if there are Mental Health Review Tribunals or hospital managers' hearings. Certainly we are aware at the moment that sometimes that is left to the discretion of individual treating psychiatrists. There are some psychiatrists who perhaps say they do not feel happy about dealing with advocates and then that person is left without an advocate because a psychiatrist says "No I do not want an advocate involved" and we do not think that is satisfactory, there needs to be a requirement that advocates are allowed to be involved. I think it is particularly important, obviously there are some very good advocacy services around and I know that some of the independent hospitals do have advocacy services. It is going to take a while though to develop them nationwide if that is something that comes out of the review of the Mental Health Act. I think we think it is particularly important that priority is given to having advocates available where compulsory powers are being used, either compulsory powers of detention or compulsory powers of treatment. As far as training is concerned, I think the role of an advocate, as we see it, is to support the decision making of the person with mental health problems. A lot of the skills that you need to be an advocate, they are not specialist skills, they are not necessarily very detailed knowledge of the law, you need to be able to be somebody who can support somebody in putting forward their own views. There are organisations, like the United Kingdom Advocacy Network, that are able to help with training for those sorts of skills.

462. Also you mentioned this question of the decision of individual medical officers to exclude a patient's access to advocacy.

(Ms Pedler) Yes.

463. In circumstances where the psychiatrist may take a clinical decision that he or she feels that this may not be in the interests of the patient's treatment, have you any ideas about how a patient may have some rights over that kind of decision, challenging that decision? Where should the decision lie that refuses access?

(Ms Pedler) I suppose it would have to go through the complaints procedure probably. If it was an NHS funded patient obviously it would go through an NHS complaints procedure or through the hospital.

464. This is a problem, otherwise there would not be decisions by individual medical officers to deny access.

(Ms Pedler) Yes. The one that we were referring to in our evidence was not a decision about a particular person and saying that this particular person, because of the situation they are in, this particular advocate is unhelpful or is unhelpful on this occasion, it was a blanket: "I do not want an advocate. I do not want advocates involved in any of the two doors for which I am responsible in this hospital" and that is a different type of decision from one where you are saying: "On this particular occasion..." or that this advocate has in the past acted in a way that has been unhelpful. Obviously you have to allow for that to take place. I think it would be the complaints procedure which would have to sort out complaints of that kind.

Mr Lewis

465. Just talking about the Care Programme approach, and some discussion that we had earlier, just from MIND's perspective what is their experience of the effectiveness of the Care Programme approach? What are the difficulties? Where does it breakdown, I suppose, from a patient perspective as much as anything else? You have already referred to the fact that where there is a significant out of area issue it is more likely there will be problems. Do you want to expand a little bit on your view of the Care Programme approach and how it works currently?

(Ms Pedler) I think we take the view that the Care Programme approach is very important. We are aware that implementation of it is patchy not only within the independent sector but also across the NHS. I think things are getting better but there is still quite a way to go in some areas. I think the main problem that we are aware of is the one about where people are referred well out of their area and as we understand it when there are plans for discharge, and there is pre-discharge planning, it is obviously very important that people from the referring area where the person is likely to be going back to do attend those meetings to sort out issues like housing, to sort out what support services are going to be available. I understand from my conversations with people in the advocacy service at some of the independent hospitals that is something which often does not happen. That is obviously not down to the independent side, that is down to the referring

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Mr Lewis Cont]

authorities that people are not turning up for those meetings. I think it is something where more is needed to be done.

Mr Lewis: It is interesting because when I was asking that question to the independent sector I think it was felt that I was being critical of the independent sector; I was not. I was wondering whether the attitude of local government staff, for example, who work on social services and housing and other areas, which are essential to Care Programme approach, is working. There is maybe less priority or different priority given where an individual is being cared for in the private sector than they are being in the public sector.

Chairman

466. This might be a question that other witnesses might wish to contribute to. Please feel free to answer.

(Ms Pedler) I am not sure that it is based on people just having different attitudes towards people in different sectors. I think it is just a question of people in social services departments being under incredible pressure and having very high workloads and if you have to spend a long time going on a long journey then that is something that perhaps does not get the same priority. I do not think it is a prejudice against people in the independent sector.

467. Do you want to add something, Dr Jones?

(Dr Jones) Yes, I cannot comment on the difference in priority applied between the two sectors, I really do not know about that, but I think what my colleague has just said is right. There is incredible pressure on social services and in a way perhaps they feel assured that when people are under the Care Programme Approach in the psychiatric service quite a bit of supervision is going on. Therefore, perhaps they get a lower priority in their very long list of priorities, whatever the sector might be. But I do not know about any difference between how the independent and statutory sectors are prioritised here.

Mr Lewis

468. Anyone else?

(Dr Jerram) Can I comment on that. I think there is a difficulty. The Care Programme approach is improving. I think the practice from the Department has now strengthened that quite considerably and certainly that is something the Commission, when they visit hospitals, look at as a way of monitoring the procedures for aftercare under Section 117 of the Act. It is varying, it varies in different places if not universally. There are enormous problems not only for the independent sector but for secure units generally liaising with home authorities. They are often quite distant. I have to say they are often quite reluctant to take on these responsibilities. It can be quite convenient to have somebody a fair distance away, as I think you perhaps suggested in your comments earlier, Sir.

469. Do you think the role of the Commission could be extended in terms of monitoring the compliance or do you think the tightening up which

appears to have taken place recently is adequate? Would you like to see your powers strengthened in this area?

(Dr Jerram) I think the way we go about it at the moment is we say how you are exercising your responsibilities for discharge. People say: "Well, we are using the Care Programme approach" and so we say: "Well, show us how you are using the Care Programme approach". In a sense the result is the same. It is quite difficult because the Care Programme approach is of course not statutory so we cannot say you have to do, we should just cajole and encourage. I think we see it as a way of monitoring compliance well with aftercare. Previous to that it was quite difficult, we could enjoin people to do things and say they should set up meetings and so forth but the strength of the Commission is that we would go to social services and they would say: "They do not tell us when the meetings are going to take place" and we would go to the health side and they would say: "Well the social workers never come". We have got over that hurdle, I think it is now time to move it on a bit.

Chairman

470. Do you want to add something?

(Mr Brown) Only to say, Chairman, the CPA is a key corner stone of the Government's policy on mental health care because it provides the opportunity for services to get together and to think about individuals. Also it allows users to know what is going to be planned for them and what is happening. I have not come across instances you describe where there is a cultural problem. I think the comments that other panel members this morning have made regarding the distance and the sense that sometimes when people are in hospital they are safer than if they were not in hospital, social workers with heavy case loads clearly have a number of people outside so they may prioritise on that basis but I have not come across any particular cultural problem in respect of the independent sector.

Mr Gunnell

471. It would follow from what Ms Pedler said earlier that MIND would take the view that was taken in the last session by providers that the Health Service Ombudsman should be able to apply what he does to NHS patients and to other patients. It should apply across the board, his remit.

(Ms Pedler) Yes. Certainly we think it is essential that there is some independent body to which people who have been treated in the independent sector outside the remit of the NHS can have access. I think obviously the independent sector is a very varied sector and there are large hospitals which have good complaints procedures but there are also small nursing homes, some of which have no complaints procedures. We are certainly aware of a case involving a Mrs Elaine Isaacs, who I believe has written herself to the Committee, and her husband's experience, which unfortunately ended in him taking his own life and she has been left without any ability to take that forward through a complaints procedure because the nursing home concerned has no

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued

[Mr Gunnell Cont]

complaints procedure and there is nowhere else that she is able to go because at the time of his death he was being treated as a private patient, although there had been NHS involvement at some stages in the past. Obviously that is a totally unsatisfactory situation. Whether the appropriate body is the Health Service Ombudsman or another independent body, I do not particularly have strong views but certainly I think there needs to be something.

472. You are happy with the person who gave evidence that they have their own internal complaints system, that they would be happy to have the Health Service Ombudsman brought in with all their patients wherever they came from and whoever funded them?

(Ms Pedler) Yes.

473. Could I ask Mr Brown, I do not know whether he heard that evidence, would there be any reason why the Department of Health would strongly feel that the Health Service Ombudsman cannot deal with complaints across the board, as was suggested?

(Mr Brown) I think the difficulties that such an extension of his role would bring are around the areas of accountability. Clearly the Ombudsman has a role because of the accountability of statutory services to the Secretary of State and that follows a clear line, if you like, that there can be some internal and other sanctions or at least publicity applied to where failures occur in statutory funded services. I think extending it to services that are not directly the responsibility of the Secretary of State raises some complex legal questions which I do not feel entirely competent to answer, Chairman. It is a difficult area. I do think the point was made that really the principle that should apply is that people should have a right to complain and a right to appeal beyond that initial level of complaint to whatever particular organisation or structure and the way a complaint should be clear and unambiguous. I would support the comments made earlier. I think there are problems in the extension of the Ombudsman's role and as well there would clearly be implications for his or her workload.

474. Do you think that the way the procedures could be tightened up from the point of view of patients within the private sector is something that the Department is likely to address?

(Mr Brown) I think when we come forward with our consultation paper on regulation generally I am sure the question of complaints and so on will need to be included in that.

Mr Austin

475. I have a question for a factual answer and if Mr Brown cannot answer the question perhaps he can supply the Committee with the information. That is whether the Health Service Ombudsman has the power to investigate a complaint from the next of kin or the relative of the deceased person?

(Mr Brown) I would have to say that I would need to take expert advice.

Mr Austin: I raise that point because I have raised this with the Prisons Ombudsman who cannot take up a complaint from the next of kin of a deceased

prisoner and that is being considered by the Home Office. I wonder if the Health Service could possibly look into this.

Chairman

476. You could look into it.

(Mr Brown) Yes.

(Dr Jones) My perception is that the complaints procedure frequently follows that route, it is the next of kin of the deceased person who make the complaint and then that goes through the complaints process, up to, eventually, the Ombudsman, if appropriate.

477. I wonder if I could turn to Dr Jerram and ask a particular point before Mrs Wise comes in on a specific question. The general picture we have got from the information we have from the Commission in your reports is that you have referred to the increasing number of formal admissions to the independent psychiatric sector and also to the number of complaints from those who are detained in the independent sector. Could I, picking up the debate that we had to some extent in the last session, ask your views on why there has been this increased use of the independent sector? Is it related to the run down of the state sector? Is it that the independent sector offers more specialised facilities for people with more serious problems? Does the increasing number of complaints reflect the gradual increase in the numbers of people using that sector?

(Dr Jerram) Thank you, Chairman. Certainly the numbers have increased and I think there are several different reasons for that. First and foremost has been the development of fairly large hospitals offering medium secure care. I have to say it seems likely that the reason that has happened is that there is less provision elsewhere. Whether it is directly related to the closure of the large psychiatric hospitals I would not like to say but it seems likely that it is. There are a number of institutions now which provide highly specialised care and that was referred to in the last set of evidence. There are a very large number of very small or smaller nursing homes which are registered to take detained patients but which might only take a very small number of such patients, or indeed only take some intermittently. They are scattered all over the place and they are quite hard for us to track down at times. I think the question of the complaints particularly relates to the larger hospitals and perhaps it is similar to NHS provision which is of a similar nature.

Audrey Wise

478. Could you, Dr Jerram, give a brief outline of the main aspects of the role of the Mental Health Act Commission. Is the role exactly the same across the public and the independent sectors?

(Dr Jerram) Yes. Our role first and foremost is to visit detained patients and we visit detained patients wherever they may be detained, be it NHS hospitals, private sector institutions, nursing homes, and we have the same access to them wherever they are. I think it is important to say that is our prime role, we go and we visit patients and therefore we are seen as visitatorial rather than an inspectorate. In the nature of

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Audrey Wise Cont]

it we do then look at what is going on around but we do not go with a preconceived set of, if you like, conditions that people have to be in, we go and we talk to the patients, we see the patients, we examine their surroundings, we examine their documentation. That is where we begin our work.

479. I was going to ask you to comment on the distinction that you make of a visitorial role. I was not even sure that "visitorial" was a word.

(Dr Jerram) Neither is "credentialling" and I have seen that in the evidence.

480. You say "only to a committed extent is it able to act as an inspectorate" and there is a quote in your evidence from the inquiry into the Personality Disorder Unit at Ashworth that says "at present it", the Mental Health Act Commission, "has neither the resources nor the statutory remit to undertake detained inspections." I wonder if you could elaborate a little bit more on the difference between inspecting and visiting. Secondly, would you like to have the resources and the remit to undertake what seems to be the more rigorous notion of inspecting?

(Dr Jerram) Perhaps it would help for background if I tell you that the Commission is made up of a fairly large number of people, about 160 Commissioners, but they are, of course, all part-time and they will spend a day or two or three days a month doing this work and many of them will be working elsewhere either in health or social services or related fields. They come from a wide range of backgrounds, predominantly professional, doctors, lawyers, social workers, nurses, clinical psychologists and other people who might be appropriate, including lay persons. In that sense it is difficult to get that number of people and it would not necessarily be appropriate to train members as full-time inspectors to go around inspecting. Does that help at all?

481. Yes, it does. It does not completely deal with the idea that there seems to be implicit the notion that inspection is a lot more rigorous than visiting. You said you do not go with preconceptions but you do go with a very explicit statutory framework.

(Dr Jerram) Yes, that is very explicit, that is our remit, but that is all we then can do.

482. Right.

(Dr Jerram) Unless we do anything else in seeing it in the context of our statutory remit. The standard that we have, I suppose, is in fact the Code of Practice. It is the nearest thing we have to a quality standard.

483. The main distinction that seems to be drawn in your evidence in relation to your findings when you do your visits seems to be between larger and smaller mental nursing homes rather than which sector they are in.

(Dr Jerram) Yes.

484. You make some pretty strong statements in annex C to your evidence. For instance, you say: "Commission members have reported a wide variation in the standards of care offered in mental nursing homes. While most strive to provide a comfortable environment..." etc., "the obligations laid down in the Act are liable to be ignored or purely addressed". That is a very strong statement.

(Dr Jerram) Yes. I think particularly in smaller nursing homes one of our predominant roles is to look at the actual operation of the Act, the Mental Health Act 1983 itself. It is sad to say that we do often find, particularly in the smaller nursing homes, perhaps where patients are not detained very often or there is not always a patient there who is detained, the knowledge and expertise amongst the staff in the actual operation of the Act is not very good.

485. Perhaps I will come back to that point in a minute and go back to a purely factual thing. The regularity or frequency of your visits. I see from your supplementary evidence that you visit 135—

(Dr Jerram) It is actually now 135, yes.

486.—mental nursing homes registered to receive detained patients. You say that you visit on average twice each year. The term average is very elastic, it can cover a huge range and be meaningless or it can be virtually equivalent to normal.

(Dr Jerram) Absolutely.

487. In your case which is it?

(Dr Jerram) We do have a visiting programme, certainly hospitals and major units would be visited four times in a cycle of two years. They may well get an extra visit as well on top of that. Most of the mental nursing homes will be visited at the same rate but clearly if there is one mental nursing home which has one or two detained patients we might say that we do not need to go and see that one every six months, particularly if it is the same patient.

488. Size also has a bearing on this particular aspect.

(Dr Jerram) Yes.

489. Now your reports go to the nursing home itself and they are invited to respond and that is all perfectly clear.

(Dr Jerram) Yes.

490. You also send them to the health authorities.

(Dr Jerram) We send them to the registering authority, yes.

491. And to the regional NHS office.

(Dr Jerram) Yes.

492. Could you give me some idea of what they then do with the reports?

(Dr Jerram) Yes, all three groups?

493. Yes?

(Dr Jerram) Commonly at the conclusion of a visit we would have a formal or an informal discussion with representatives of the hospital or the nursing home, whichever it is, and a number of issues are often resolved at that level. We can point out things which we think are inappropriate or wrong and they say: "Yes, we will do that" and we will check that up on a subsequent visit. The health authorities will nearly always respond to the reports, they acknowledge them, and if there are particular issues within them that they want to discuss with us or raise with us they will do so. Occasionally they will say that they will take this up with the organisation involved. With regard to the NHS ME, representatives from the Commission would meet with the different NHS MEs on a fairly regular basis, usually annually, and

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued

[Audrey Wise Cont]

we will talk about general issues and also talk about specific issues which may come up in the course of visits.

494. Do you make findings that touch on the role of purchasers?

(Dr Jerram) Yes?

495. Or only on the providers?

(Dr Jerram) No, we do have some effect upon purchasers and at a full visit—what is called a full visit which we will do every two years—up to now we have met with representatives of the purchasers and we would ask them issues to do with how they are monitoring their contract, what sort of quality assurance programmes they have in place. There are particular issues for institutions, if I can use that phrase, which take people from really quite a wide area, within the NHS, for instance like a medium secure unit or regional secure unit, but in the NHS there will be identified a lead commissioner, one of the local health authorities will be the lead commissioner for that unit, and therefore they will act as a spokesperson for other health authorities. That is useful. We do not have the same arrangement, obviously, for the private sector so far as I am aware.

496. Do you ever make findings that touch on the role of the health authority inspectorate?

(Dr Jerram) I am not quite sure that we do actually, I do not think we necessarily do. We are aware that there are other people who inspect, if you like, some of the services that we inspect. I have done a joint visit with a social services inspector on one occasion, that was actually very useful, but we are aware, if you like, that there is a number of other bodies who are inspecting. Clearly, some of items will be common but not in general terms.

497. I notice in your evidence that you say "... The Commission is usually notified of new registrations but the relevant registering health authority. Sometimes this does not occur..."

(Dr Jerram) That is right.

498. "... and there can be a delay in the Commission undertaking its first visit." Can I ask what happens then? Do you just say: "Oh, we have got this referral now, let us beetle along and do a visit" or do you take some other sort of action?

(Dr Jerram) No, we would arrange a visit. From time to time it does come about that you hear about it almost by word of mouth. It is a strange situation.

499. What effect does this have on your confidence in the registering health authority concerned?

(Dr Jerram) We have suggested elsewhere that compliance with Mental Health Act procedures should be a condition of registration. There is a question about that later on and it would be very helpful if the registering authority could notify us. We do write to health authorities now on a regular basis and ask them to provide a list of registered mental nursing homes in their area.

500. It is a statutory duty you are carrying out, is it not?

(Dr Jerram) It is a statutory duty we are carrying out to visit detained patients.

501. So if the registering authority does not take seriously its obligations to notify you then it is surely impeding you in carrying out a statutory duty. I would have thought that you would have taken a very serious view about that and done something?

(Dr Jerram) All we can do is write to the health authority, write to the registering authority.

502. What about somebody above the registering health authority? What about the NHS Executive? What about the Secretary of State? The registering health authority has got duties itself. It does seem to me that if it does not even get round to notifying the Mental Health Act Commission it is not going to be very good at carrying out its own duties.

(Dr Jerram) Yes.

503. Is there anything else that you think you could do? It sounds, you see, as though you are dependent on their goodwill. That does not seem to me to be very satisfactory.

(Dr Jerram) Yes. For the last four years now we have written to health authorities reminding them and asking them to notify us of any mental nursing homes. There are difficulties I have to agree.

504. There are difficulties, what do you mean?

(Dr Jerram) There are difficulties in that.

505. Not difficulties in them doing it?

(Dr Jerram) No, there are difficulties in the process, I accept that yes.

506. Do you not think then that you should get, if necessary, the final statutory authority, the Secretary of State, to say to such an errant health authority: "Include this in your system automatically"?

(Dr Jerram) Yes, we can do that.

507. You can do that?

(Dr Jerram) Yes.

Audrey Wise: Do you? Now and again.

Chairman

508. It might be helpful if you are not clear if you follow up with a written note. I accept this is a very complex area and we do not expect our witnesses to know the detail of every item. Particularly when Mrs Wise is asking questions, we get into some great detail which is very important to us.

(Dr Jerram) There are two different sorts of legislation involved.

Audrey Wise

509. The confidence in the whole edifice does seem to me to depend on the people who have the notifying duty actually carrying out that duty otherwise how on earth can you say to providers: "Carry out your statutory duties"?

(Dr Jerram) Yes.

510. Since a lot of your complaint appears to be that smaller nursing homes in particular are poor at documentation, it seems to me they may just be following the example set by the registering authority itself in some cases.

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Audrey Wise Cont]

(Dr Jerram) I have to say that our experience is that if we do write to the health authority they respond very rapidly and apologise and promise not to do it again.

511. Ah, and promise not to do it again. Right okay. Can I go on to ask in the investigation of complaints do you involve the health authority or a related NHS trust or a registration team or anybody? How do you investigate?

(Dr Jerram) Our complaints remit is quite limited, although that may have changed with a recent court judgment but it is quite limited. We do in fact now investigate a very small number of complaints, that seems to be predominately because of the NHS complaints procedure. A lot of the time people will contact us and we monitor their progress through the NHS complaints procedure.

Chairman

512. Dr Jones, do you want to come in?

(Dr Jones) No, it is really about the Mental Health Act Commission, a point related to that.

513. Sorry, Dr Jerram, please continue.

(Dr Jerram) Much of it is nursing and helping people through the NHS complaints procedure. In fact we only now investigate a very small number of complaints, single figures. That complaint, the findings of the complaint will then go to the complainant and to the trust or organisation and to the health authority.

Audrey Wise

514. Will you have any role in auditing clinical governance?

(Dr Jerram) I think the answer to that is that we do not know.

515. Do you have a view on whether you should?

(Dr Jerram) Quite a lot of what we do does have some impact on clinical governance in the sense that we do examine, we talk to patients, we examine clinical notes and we have quite a good grasp, quite a lot of the time, of what actually goes on. If somebody does not see their responsible medical officer for months at a time we are aware of that. I am not sure we are in a position to monitor what actually goes on when they do see the responsible medical officer.

Chairman

516. Dr Jones, do you want to comment?

(Dr Jones) A point related to the Mental Health Act Commission and from the perspective of the elderly, there are 450,000 elderly people in nursing and residential care in this country, many of them with substantial mental health problems and some of them in homes registered for the elderly mentally ill. If you take Nottingham, for instance, with all of the homes in Nottingham which are registered for the care of the elderly mentally ill, none of them is registered under the Mental Health Act, so they are not within the remit of the Mental Health Act Commission. Yet some, not particularly in Nottingham, I would say, but round the country,

have raised concerns that some of these people are de facto in detention really and yet there is no inspection. I do not want to say there is abuse going on, by any means, but certainly I think this is an area of concern and we should address this area. There are very large numbers of people, particularly the elderly with mental health problems, who perhaps merit more oversight than they get.

Audrey Wise

517. So the boundary of the remit could stand some examination?

(Dr Jones) Yes.

Chairman

518. Could I ask a couple of specific questions, Dr Jerram, in respect of answers that you gave to Mrs Wise. She asked a question about whether you might jointly involve health authority registration, a social service registration team and I think you said in certain circumstances you had visited with a social services team.

(Dr Jerram) Yes.

519. If a complaint in respect of a detained patient is made that had a bearing on the wider registration requirements, would you automatically involve them or would this be something that you may do after seeing the patients? If you were aware for example—I cannot think of a good way of illustrating this—that something the patient was concerned about related to a broader registration criteria of the establishment concerned, would you automatically bring in social services or the health authority registration, depending on the circumstances, when you went to see the patient? Without mentioning a patient, what were the circumstances when you involved the social services in this particular instance?

(Dr Jerram) It was the specific nature of the unit that we were examining at the time.

520. You mean the bricks and mortar?

(Dr Jerram) No, the clientele, the client group. In terms of something arising from seeing a patient we would be involved with the patient first. I think then if there was something of the nature you raised, we would directly ourselves via the owners or managers, whoever, of the institution involved have to direct it to the authority.

521. Can I ask a specific point again about your evidence, picking up something that Audrey touched on. You have concluded that registering health authorities should have discretion to withhold registration from mental nursing homes to admit detained patients on the grounds of lack of compliance with Mental Health Act procedures. Could I ask you specifically why would it be useful for health authorities to have the power to withdraw a detention facility whilst maintaining a mental nursing home registration?

(Dr Jerram) I think our view on that is that somebody may well be running perfectly competently a nursing home but they are not managing the Mental Health Act procedures, perhaps because they do them so rarely or whatever. Therefore they would be best advised not to do that.

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Chairman Cont]

522. Can I ask a straight question why that might be the case, to help the Committee?

(Dr Jerram) They do not.

523. Insufficient staffing, lack of training?

(Dr Jerram) It is probably staffing, training, expertise, the responsibilities under the Mental Health Act are quite onerous in the sense of receiving documents, ensuring patients' rights, referring to Mental Health Review Tribunals, informing nearest relatives, making arrangements for renewal of detention when appropriate and having an appropriate responsible medical officer. If the game is not worth the candle if they cannot do all that, they would be better advised just to stick to running a mental nursing home.

524. It makes you wonder why they were placed there in the first place.

(Dr Jerram) Absolutely.

Julia Drown

525. I am interested in whether the Commission believe that the "fit persons" provision of the Registered Homes Act offers sufficient scope for health authorities to monitor Mental Health Act procedures in registered mental nursing homes?

(Dr Jerram) As I understand the Registered Homes Act, there are various grounds that people can be disqualified, if you like, from running a nursing home of this nature. The "fit person" is the kind of catch-all, as it were, to get somebody if you cannot get them on the other grounds. The information that we have from the Tribunal appeals is people have been disqualified on a very wide range of grounds, some to do with their own health, some to do with lack of compliance with procedures. Certainly it seems to work reasonably well from that point of view, although of course it is a fairly slow process because of the appeal to the Tribunal. I have not a lot of experience but it is possible for emergency closure to take place.

526. Would you think that wide scope should be transferred to the Regional Commissions for Care Standards?

(Dr Jerram) Yes, I would have thought they would be an appropriate body.

527. I think Dr Jones mentioned earlier about how concerns have been raised about people who are effectively in "informal detention" in mental nursing homes which are not registered to take detained patients. I wonder whether you would like to see the Commission's role extended to cover all mental nursing homes because of that reason?

(Dr Jerram) The question of de facto detention is one that has exercised the Commission over many years. The Committee will be aware that the Bournemouth Judgment suggested that the legislation had in fact been misread, that is not now so, though we understand that there are proposals in somewhere for this issue to be addressed. We continue to be concerned about people who are, if you like, incapable but informal. There is also the "who decides" document but it would be an enormous resource implication if our remit was to be extended either to all informal patients in psychiatric hospitals or to all mental nursing homes.

528. You are not clear really whether it should be done or not?

(Dr Jerram) It would be an enormous resource implication.

529. Okay.

(Dr Jerram) It may well be that the question of capacity, of course, will be dealt with by other reviews of the legislation. I do not know if Mr Brown would like to comment.

Chairman: I think we might get on to the review in a moment or two and specific questions to Mr Brown.

Julia Drown

530. I would be interested in all our witnesses' views on whether they feel the regulation of mental health services should be done by the Regional Commissions for Care Standards or the Commission for Health Improvement?

(Dr Jerram) Right. It is whether the Regional Commissions or the Commission for Health Improvement? Much of the roles we feel could probably be best done by the Regional Commissions in the sense that they will have some local knowledge. Clearly they will be well equipped to do this. The suggestion in the document is that it is people who are going to be doing it full time, either permanently or for a period on secondment from other organisations and therefore they would strike a balance between having a fairly consistent approach over a wide area and yet being aware of local facilities and local obligations.

531. Do you think any mental health services should be looked at by the Commission for Health Improvement?

(Dr Jerram) I am sure they will be, yes. It will be more in the terms, depending upon the National Service Framework, of standards of treatment and then being followed through.

532. In your view it is not clear which should be done by which?

(Dr Jerram) I do not know. Could I just say I am not sure if the CHI is going to do it or get other people to do it and then monitor it.

(Dr Jones) We are quite clear that the same standards we think should apply to mental health services whether in the independent sector or the statutory sector- the same high standards. We feel that we see the prospect of good high standards being required in the statutory sector- one should see that applied in the independent sector as well. How that is done, we can debate. It may be CHI, it may be contracted out to HAS 2000, it may be something else altogether. We have some interest in HAS 2000 as part of the Royal College is involved with that. But certainly we want to see the standards regulated just as well.

533. You would not object if that is done by the Regional Commissions for Care Standards?

(Dr Jones) That seems to me to be a different thing, perhaps more related to continuing care institutions. I would see a role for dual involvement with some sectors. Take for instance nursing homes for the elderly mentally ill. There is a need to assure the sort of quality of life, continuing care standards, going on

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Julia Drown Cont]

at a day to day level there. And here I would wave at you—since I have not had a chance to wave it at you—a document from the Centre for Policy on Ageing, “National Required Standards for Residential and Nursing Homes for Older People”. Certainly I would advocate you have a look at this document and hopefully back it. It is very important in this kind of day to day assurance of quality of care. But with CHI or CHIMP I think we are looking at the quality of services and the processes that services undertake. CHI should be free I think to follow patients wherever they go which would include such homes, and many of the institutions we have talked about this morning. Residential and Nursing Home care aspects perhaps come down more to the Regional Commissions for Care Standards.

(Mr Brown) Just on the point about regulation, as Mr Staniforth said when he came before you, we will be issuing a document which tries to look at these various options because there are clearly pros and cons. As you will have heard earlier this morning finding the right boundary is problematic and of course we would be interested in hearing what people who actually have to operate the system say about where that boundary would fall. On the point of the Commission for Health Improvement, again as Mr Staniforth said, it is principally about improving the standards of care within the NHS, where the NHS is paying for patients within the independent sector then it will have a role to investigate. I think clearly, as envisaged, the Commission would carry substantial weight in terms of its recommendations, its report, its judgments about what was and was not acceptable.

Chairman

534. Can I pursue one or two points with Mr Brown. I know my colleagues want to ask some questions. If I can quote briefly from some of the written evidence that the Independent Health Association have submitted to the Committee. They say “... The absence of formal processes and requirements on the part of the NHS to include the sector in the planning, development and provision of mental health services ... is of considerable concern to providers...” They go on to say: “The status of the sector with respect to the Government’s recently announced quality and clinical governance framework is also unknown.” Now there are lots of developments taking place currently which have a major impact on the mental health field, what is the involvement from your point of view of the independent sector in developing, for example, the National Service Framework for mental health?

(Mr Brown) The National Service Framework has been developed with the help of an external reference group, including within that group a number of people from the independent sector, as defined by people not employed in statutory services. So we had included people from the voluntary sector who both represent and campaign for mental health issues. Many of those organisations also provide services as well. So including that definition of the independent sector, and many of those are not-for-profit organisations, we felt that we had within the reference group the right mix of people to help us do

some initial work on the reference group. It is true that the Independent Health Care Association was not represented on the external reference group, as were not numbers of other national bodies which might reasonably have said they should have a place. I am afraid at the end of the day, Chairman, it came down to trying to make the reference group manageable and at 43 I think we thought we had got far enough already. In addition to that we did have a number of sub-groups within the external reference group and again we included a number of people from the independent sector. Again, I am afraid to say that not everybody who wanted to be part of that process could be and we received a number of letters from individuals and organisations arguing strongly that they should have been involved and had something to say. To all the people who wrote into that, we outlined that if they wished to submit written views or contribute to the process in any way we would guarantee that their views would be circulated to all members of both the reference group and the sub-group. Although we could not take everybody because of size I think we thought we had done the next best thing by saying if they had views they wanted to communicate we would certainly do that.

535. You would refute any suggestion—I appreciate I am talking to a civil service rather than a politician—there was political interference in the way in which this review was constituted? You are not giving us the impression that there was a decision to exclude the private sector, you feel it was impossible to include all the people. These are questions we will put to the Secretary of State in a couple of weeks time, I do not want to embarrass you.

(Mr Brown) It is important to point out that the external reference group was chaired by Professor Graham Thornicroft as an independent. The Department was on the reference group as observers, we were not active participants. So Professor Thornicroft had a strong say in the membership of both the reference group and the sub-group. I was not aware in any part of the process of any political decisions about the independent sector but it is a question you can put to the Secretary of State as well.

Audrey Wise

536. Could we perhaps have a list of the membership?

(Mr Brown) By all means, no problem.

Mr Austin

537. Having embarked on the preparation of the National Service Framework and the review, could you share with us at this time the Department’s thinking about the structure and possible future regulation of the independent sector? Could you let us know whether you are considering any proposals for developing service contracts to be applied or recognised by the independent sector?

(Mr Brown) The National Service Framework is one of the mechanisms, not the only one, that we are seeking to modernise mental health care through the NHS and local authority social services. It is principally about reducing variation in service and

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Mr Austin Cont]

improving the general level of services available to people locally. The Service Framework will principally apply to how services are constructed within the defined health community. In terms of its impact upon the independent sector then clearly where local health communities for a variety of reasons are commissioning or feel they need to commission from the independent sector then the standards in the framework would need to apply to the individuals that they send to the independent sector places. I would hope that the independent sector would take very careful account of the standards that we set out in the Framework for incorporation within their procedures because we think that the Service Framework will be a powerful document to improve mental health care. I do not think there will be any grounds for people to ignore the extensive consultation with regard to the external reference group and indeed the signals we have sent to the NHS about how important it is. I think there are two ways that it would apply. In terms of regulation of the independent health care sector, again I would come back to the earlier answer I gave which is there is a number of ways of regulating the sector which are slightly different from inspecting or ensuring that standards are maintained. The two are connected and, as Mr Staniforth said earlier in his evidence to this Committee, we recognise the 1984 Act is out of date and needs to be improved and when we consult on these issues we will need to think about a number of those options and which way it could fall. I do not think there is any doubt, and Mr Staniforth said that we recognise that regulation of some sort is required, it is a question of how you construct that.

Chairman: Are there any colleagues who want to ask any questions on this or witnesses who want to comment before we move elsewhere? If not, fine. Can I bring in Julia Drown.

Julia Drown: I wanted to ask about the problems of title, protection of titles in mental health. I wondered if any of our witnesses had any views on that, whether you would want to restrict entry and accredit the counsellors for example?

Chairman

538. This is particularly something the Royal College picked up.

(Dr Jones) I do not think it mentioned the term "protection of title", it sounds like protecting the hereditary peers.

Julia Drown

539. Certainly when we spoke to consumers and patients they were very conscious that people sometimes go and talk to somebody who calls themselves a specialist and therefore they think they have medical qualifications and in fact they have not. We would like your views on that,

(Dr Jones) Yes.

Chairman

540. We have had evidence quite clearly that people were seeing "consultants" in clinics who were not medically qualified but there was an assumption. They were the reason I mentioned the Royal College is you specifically talk in your evidence about "... those practising independently in out patients setting or in independent psychotherapy or counselling are subject only to the regulation of their professional registration body—where there is one". Clearly you have got some anxieties and we would be interested in learning a little bit more about what those anxieties are?

(Dr Jones) That is exactly right. We have anxieties in the area that people—really as you stated it very well—can stick up a brass plaque saying what they like, as long as it does not actually infringe trading standards or advertising standards then they are free to do what they like. We feel there is too much freedom in that way, that people should be identifiable as mental health practitioners of some sort if they are to be plying their trade supposedly as mental health practitioners of some sort. If they are claiming some sort of expertise this should be identifiable in terms of a professional body. There is a problem. There is a variety of practitioners in the mental health field and I suppose it is a growing area. Doctors obviously are regulated by the GMC, but you can call yourself a therapist and you can get away with all sorts of things. We do not necessarily have answers in terms of detailed legislation to give you, we just want to highlight this problem where like you and others we believe patients can come to grief.

Julia Drown

541. Rather than just saying you should protect the following titles "consultant, counsellor" or others, it should be that anybody who is obviously practising with the intention of giving mental health care should have some qualification?

(Dr Jones) Broadly. There are specific examples. We mention in our evidence that the UK Council for Psychotherapy and the British Confederation of Psychotherapists advocate gold standards, if you like. There is the British Association of Counselling which again we would support but there are all manner of people calling themselves by all manner of names. It is how to cover all of them which is problematic.

Chairman

542. It strikes me that one of the most effective methods of helping people that I have come across has been help by other psychiatric patients. The development of user groups certainly in the last 20 or 30 years has really helped a great number of people. You would not be suggesting that there should be some arrangement that would apply to groups of this nature? It is where you are saying that you are making money out of offering certain services. Clearly we are anxious to look at ideas which could be brought in that are practical. What you are saying is yes you are flagging it up as a problem but you have not come up with an answer?

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Chairman Cont]

(Dr Jones) I am afraid we do not have specific legislative proposals but I think that would be the emphasis. Where people are plying their trade, advertising that they offer this or that service, one has concerns about the regulation of the service they are apparently offering, or rather the lack of regulation.

543. You would be looking at minimal standards of some kind even if people were not appropriately qualified or even if they were qualified. There should be checks of the kind we have in other areas.

(Dr Jones) Yes.

Julia Drown

544. You mentioned advertising, that was my last question really, what problems do you think there are with people advertising services? Again we have had proposals about how that should be better regulated.

(Dr Jones) Yes, we do not have specific legislative proposals but really, as I say, concern and emphasis that there should be proper reference to proper professional qualifications, professional bodies where there be such, and that there should be efforts to establish that there be regulation by appropriate professional bodies for such practitioners rather than freedom to simply be a therapist undefined.

545. You think current regulations are not strong enough?

(Dr Jones) That is our feeling, yes.

(Ms Pedler) Certainly we would not want to undermine the self help groups to which you referred but I think we do have some concerns at MIND about people having the ability to set themselves up and call themselves a counsellor or therapist without necessarily needing to have any recognised qualification. I think there is a big growth in that sector. There is a lot of interest amongst users in mental health services in wanting alternatives to medication and a lot of those are not available within the NHS so people are inevitably having to turn to the private sector. I think there is a lack of regulation in that area.

Chairman

546. How would you do it? This is the important question that we are looking at. We hope to come up with some practical suggestions. We have been talking to experts who are picking up problems but have not got solutions. Have you any ideas on solutions in the areas you are talking about?

(Ms Pedler) I think that what you would need would be some sort of accreditation body and people would have to have certain qualifications or certain skills in order to get the accreditation from that body. I think that is the road I would see things going down.

(Dr Jones) Certainly we could make specific proposals I think in relation to the area of psychotherapy and counselling. We would be happy to undertake to try and write to you to flesh that out for you?

547. That would be very helpful. Clearly it is an area that although you have explored this area more in relation to psychiatric treatment, clearly it does

relate to the areas that we are all concerned about. It would be very helpful if you could send us further information.

(Mr Brown) I understand, Chairman, we have offered to send you further material on titles which should be with you tomorrow.

Chairman: Thank you very much. That is very helpful. Are there any further questions?

Mr Amess

548. Two just very quick points, to Mr Brown and Ms Pedler. The Secretary of State is coming to give evidence on 13 May at 4 pm, and I would not want to misrepresent him but I get the impression from time to time he is not entirely enthusiastic about the independent sector. I wonder if you could possibly tell us if there are any plans afoot from the Department to try and shrink the contribution that the independent sector is making to mental health services? The question to Ms Pedler is do you need more money because as MPs we know what a wonderful charity you are, and you do such fantastic work in all constituencies locally, and if you did get more money, in terms of what we have been talking about this morning, perhaps even saving some money in a sense, do you think you could do even more than you are doing at the moment?

(Mr Brown) I am aware of no plans to shrink.

549. No plans to do so at the moment.

(Mr Brown) No.

Chairman

550. Ms Pedler, do you need more money?

(Ms Pedler) I think the answer to that must be yes.

Mr Austin

551. Could you do something with it.

(Ms Pedler) I am sure we could make very good use of additional resources.

Audrey Wise

552. Are you aware, any of the witnesses, of particular problems in the mental health field as they impinge on minority ethnic groups and whether the current arrangements for treatment, care, whatever, impinge fairly on them, adequately on them, are good standards of care? I once had a conversation with a psychiatric consultant who was himself black and, for example, he said that in his experience there was a strong tendency to confuse social problems with psychiatric problems and this was one explanation for the disproportionate impact of the psychiatric services on black people. Does anybody have any views about that and whether it is properly addressed across the sector, including the independent sector?

(Dr Jerram) The Commission I think has strong views on this issue. For the last some time now we have regarded this as what we call a matter requiring particular attention on visits ranging from what is available for representatives from black and minority and ethnic minority patients when they are

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Audrey Wise Cont]

admitted through recognition of cultural, dietary, other factors, understanding of the culture from which they come, the provision of adequate interpreting and other types of services on a professional basis rather than asking family members or passing hospital staff to interpret for them. We recognise that it is a continuing issue which does have to be looked at.

553. Any other comments?

(Ms Pedler) Yes for us too it is a very important issue and I think there is still a long way to go in getting services which are sensitive to the needs of black and ethnic minority patients. I am sure that certainly in the medium secure sector that black patients are over-represented, there is a much higher representation at the more secure end of the system and there is quite a lot of medium secure in the independent sector so in the context of today's inquiry that becomes relevant. I think it comes up in the context of training. We have got a section within MIND called Diverse Minds which is looking at developing services which are more sensitive to the needs of black and ethnic minority communities. A particular focus of that is on training and providing the proper training from primary care upwards and there would be no reason why the independent sector could not be involved in having access to that training and that is something we would like to develop further.

(Dr Jones) I would back the comments that have already been made. I think it is probably, from our perspective, more of an issue that we have seen develop in the statutory services. They probably deal more with these problems. I cannot really comment on how well or badly they are dealt with in the independent sector. I have no evidence on that. We can always do better and are striving to do better. Obviously this is a very complicated area that you have raised. There is research under way at this moment to try and clarify the relative proportions of contribution of social, genetic and environmental factors and so on.

(Mr Brown) It is a very serious issue for mental health services in this country. As Margaret has said black people are over represented in the more secure accommodation and under represented in access to the walk in therapies such as psychotherapy so they get the worst on both sides. We would want to address this very firmly in the National Service Framework by ensuring that the standards reflect the need for services to be culturally appropriate and properly provided.

Chairman

554. Within the Royal College is there an effort being made to look at developing greater expertise and insight in this area? For example I was struck when we visited Stockton Hall by the extent to which many of these patients were from Afro-Caribbean background, maybe from the London area or from the South of England. We were fortunate there in meeting a black female psychiatrist who impressed me very greatly. I wondered how many of your colleagues have a similar background to that and have an insight into the needs of those patients that

may be missing, with great respect, among psychiatrists without that background? I am sure you understand the point I am making.

(Dr Jones) Sure. There is a very strong trans-cultural psychiatry group in the Royal College. We are interested in promoting and exploring precisely this area. I cannot quote you figures, if that is what you are asking, on how many of our members are from ethnic minority groups. I would venture to say that they probably form more of our membership proportionately than in other specialities in medicine. So we are perhaps "better placed" to address such problems. It is an issue that the Royal College has been addressing for some years now to be more ethnically aware and to promote the interests of ethnic minorities both in terms of services and in terms of ensuring that ethnic minority psychiatrist members of the College are properly treated.

(Mr Brown) We have commissioned the Royal College of Psychiatrists to produce a register of non white English consultant psychiatrists and I hope that will be published soon so that people will know where people from their own ethnic background are based. I am not entirely sure of the publication date.

555. Dr Jerram?

(Dr Jerram) Could I just add that the Commission itself is very committed to increasing its black and ethnic minority representation amongst commissioners who have to visit patients.

Audrey Wise

556. Another question on a different topic but again I think perhaps a problem area. When this Committee did its inquiry into children's health, child and adolescent mental health assumed a much greater importance in that inquiry than we had originally anticipated. It was very clear that those involved professionally in the field of psychiatry of youngsters, children and young people, felt very much as though they were at the lower end in terms of prestige and clout than their colleagues dealing with adult psychiatry. This was very strong, very prevalent, not just talking about a person. Now do you have any views on the adequacy again of adolescent psychiatry and can you tell us to what extent that also is found to be moving more and more into the independent sector and does this have any effect?

(Dr Jones) If I may comment briefly on that. It came up with the evidence of the earlier witnesses. I think this is an inadequacy of the NHS in the area. We have quite a growth of independent sector services for children and adolescents in the child psychiatry sphere and wider spheres, precisely because there are not the statutory services we feel that there should be. It is not that we do not feel that they should be cared for in the NHS, the services are not there to care for them. I guess the private sector entrepreneurially moves in to develop services. We have great concerns about that. It comes back to planning, co-ordination of services again. Concerns about children and adolescents being treated a long way from home, and all of the concerns you mentioned earlier arise. The root of it, as we would see it, is the inadequacy, basically, of the provision of services in the statutory sector for this group.

15 April 1999]

MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES

[Continued]

[Audrey Wise Cont]

(*Mr Brown*) There has been a reduction in the number of secure places for adolescents in the NHS over the last few years and an increase in secure places in the independent sector. The attention that the NHS priorities guidance attaches to the requirements on health and local authorities to develop services for child and adolescents we think should establish a better planning cycle and in addition some 84 million of the modernisation fund has been targeted at developing child and adolescent mental health services over the next few years. Although the Service Framework will be restricted to adults of working age, clearly there are some boundary issues that we need to address for children in adolescence who may continue to need some sort of care when they become adult and of course providing proper care for children with mental health problems in a sense is one way of tackling the demand in later years.

Mr Gunnell

557. In a sense making up that provision is never a rapid process.

(*Mr Brown*) Indeed not.

558. Surely that means the Department of Health cannot simply leave the private sector to regulate itself and say it is too difficult to bring a lot of the regulatory framework into the private sector. It is not going to be sufficient to do that when we are short of the necessary space in the statutory sector.

(*Mr Brown*) The reduction, Chairman, in NHS beds is in part, I am sure, for local service reasons but there are also professional issues here around exactly where children should be treated and exactly whether children should be in hospital and a number of complicated issues. Where the independent sector currently provides those services and where any proposals on regulation of mental health would, I would have thought, need to consider that child and adolescent would be part of those proposals. Though in a sense in the Service Framework we have picked off adults of working age I do not know that that automatically assumes we would exclude it in any regulation until the consultations become clear.

Audrey Wise

559. Pursuing something that you said about encouraging local authorities to provide more secure units, could I ask whether the Department is liaising with the Home Office because there is an issue here relating to the relationship with adolescents who have committed offences. This Committee visited a splendid local authority unit in Northamptonshire, absolutely splendid, who had a lot of problems in relation to the prison service. It is not much use putting a valuable investment into rehabilitation if as soon as they make some progress they are banged back in prison. Do you liaise with the Home Office on this question? Some of the issues as to whether a child is via the penal system or in some other way really might be accidental, whether a child has been caught in fact, you might have another child who has done exactly the same things and never been caught but comes up for Care and Protection and somebody else

is through the court system. I think it needs a lot more encouragement, it means actually making sure that the investment is properly utilised.

(*Mr Brown*) It is not part of my direct responsibilities because that really falls to another part of the Department but I do know that in common with ourselves they liaise very closely with the Home Office on the overall pattern of services. Indeed that has developed quite substantially over the past couple of years. I think what we are looking to develop essentially is a sense of the health community locally, including all the players—the police, the criminal justice system, local authority, health—trying to come to some local views about the services necessary locally and what the investment necessary then is to meet that and over what period of time. Certainly we would have an expectation that people locally were discussing together the footprint of their local services and making the best use of those and I can assure you we do. If you want more information on that particular topic I can get that.

560. I would be grateful for that and, of course, it is another example of two different pots of funding, is it not, that has got a very great bearing on it. Of course, the local authority secure unit is more expensive at the time, not necessarily more expensive in the long term but the prison service does not want to cough up. I think the liaison here and the kind of approach of joint funding or getting over the two funding streams problem is really very, very important if you are to make any progress.

(*Mr Brown*) I will have someone write to the Committee. I will include within that the document recently published on the prison health service generally which seeks to establish a health policy within the Executive because I think that will establish much more of a health focus for not only children but a number of other health problems. I will write.

Chairman

561. Thank you, Mr Brown. Any other questions from Members? Do any witnesses want to add anything before we conclude. Is there anything we have not touched on?

(*Dr Jones*) Can I just mention something to do with general practice. I want to say we have certainly shown through work in Nottingham that GPs now have to do a tremendous amount more work than they used to have to in the independent sector, nursing homes, residential homes and so on and of course they cry for more money for that with some justice. But a positive development from this could be to develop some specialist GPs for this kind of work or GPs with a special interest who were registered to do this kind of work. One can see this having applicability more broadly, GPs involved with homes for rehabilitation, substance misuse, child and adolescent work for instance, wide applicability, which could be pursued in a constructive way. Protocols of care could be developed. There could be educational crossover between GP primary care, primary care, the independent sector, nurses in primary care, nurses in the independent sector; and so on. I think there is quite a lot of work that could be positively developed

*15 April 1999]*MR MARTIN BROWN, DR TIM JERRAM,
MS MARGARET PEDLER AND DR ROB JONES*[Continued]***[Chairman Cont]**

in this area and piloting could be constructively taken forward, even concepts such as teaching nursing homes, that kind of thing.

Chairman: I think we might have got on to that had our two GP colleagues been here. We do tend to spend a lot of time on the GPs' concerns but when they are not here we go on to other issues. I apologise for not raising that. Can I thank you all once again

for coming along today. I think you probably will have gathered from some of the points we have made that there is a great interest in mental health on the Committee and it could well be that perhaps at some point in the future we will look in more detail at this area and we may well meet you again. We are most grateful for your help. Thank you.

Letter from the Chief Executive, Mental Health Act Commission, to the Clerk of the Committee (PM 94B)

The Committee suggested (Question 508) that a written note could be helpful on the question of the Commission's knowledge of the existence of mental nursing homes registered to take detained patients under the Mental Health Act 1983. I shall therefore deal with this below.

There is no statutory duty on health authorities to notify the Mental Health Act Commission when registering mental nursing homes to receive patients detained under the Mental Health Act. Whilst the Commission has no objection to such a duty being imposed upon Health Authorities it is of the view that the current arrangements between health authorities and the Commission over this matter generally work well. The Commission has written to all health authorities requesting that it be notified of any new registrations of homes that enable such homes to detain patients under the Mental Health Act and reminds health authorities of this request every two years. On those occasions when the Commission is made aware of the existence of a home registered to take detained patients that it has not been notified of by a health authority, it has written to that health authority to point out the health authority's failure to comply with the Commission's stated request. In the Commission's experience this is often a sufficient remedy.

The Commission, which has some 170 members, many of whom work within mental health services across England and Wales, often becomes aware of services whilst they are still being developed, both from its own membership and from mental health services. It is, furthermore, often contacted directly by mental nursing homes who are seeking or have sought registration to take detained patients, who may want information on the Mental Health Act or may simply wish to announce themselves to the Commission.

I hope that this is helpful to the Committee but I am, of course, willing to attempt to answer any further questions that it may have of the Commission.

28 April 1999

Letter from the Medical Director, St Andrew's Hospital, Northampton, to the Chairman of the Committee (PM 20B)

Further to my appearance with others before the Parliamentary Health Committee I would like to take the opportunity to comment on three matters that came up at the session:

1. You asked me specifically about information you had been given that the opening of St Andrew's Hospital had in some way denuded the local trust of consultants to the point where it had to consider closure. I gave you an answer on this but I would like to put the record completely straight because I believe you have been badly misinformed.

I came to work at St Andrew's Hospital in November 1995 having been Medical Director of Nottingham Healthcare NHS Trust and a Consultant Forensic Psychiatrist there. I had come from a service in Nottingham that has a very high national reputation as a good provider of mental health services to its local community and, having worked there for 17 years it is certainly my experience that we had striven very hard throughout the services to provide a good, responsive, well balanced service. Well balanced with both adequate numbers of beds and a very good community set up. I was shocked, in coming to Northampton, that this sort of service was not available to the citizens of Northampton. I quickly learnt that local general practitioners in Northampton were very unhappy and had been for many years, with the service that was provided.

In January 1996, just some two months after I had come to St Andrew's I was approached individually, by all five acute general psychiatrists in the neighbouring Trust saying, either could we take over the running of their services or could they have jobs at St Andrew's. They were all very unhappy with the service that they were being asked to give to the local community. It was under resourced, working in what I can only describe as quite disgraceful buildings (that is the wards, not the offices) and without an adequate community facility. Many of them had worked for that Trust for very many years and were at the point of exhaustion. I was also approached by three of the consultants from the Mental Health Trust in the other part of Northamptonshire, Rockingham Forest. At that point I went to see my two colleague medical directors in the two Trusts to indicate to them that a considerable proportion of their consultants were so unhappy they were wanting to leave and indeed, were prepared to give up psychiatry altogether or move to another part of the country.

*15 April 1999]**[Continued*

Indeed, in the case of three of them, were prepared to emigrate rather than continue working in their services. Interestingly, one of the Trusts, Rockingham Forest, responded to this, spoke to their consultants and started setting about rectifying the very real problems that those consultants indicated. They have, in fact, not only not lost any consultants but have managed to recruit more. The other Trust chose to do nothing. The consultants remained overworked and very unhappy and prepared to leave.

Because I responded to concerns of colleagues because I felt it would be better to keep the consultants working in the locality in which they all lived, I tried to find jobs for them at St Andrew's. I have to point out that at that time we neither had advertised nor did we have an expansion. Nor, indeed, did we really want to take on additional consultants at quite considerable cost. We took a long term view that we would have work for these consultants. You are right then to say that as a result of that the local service nearly collapsed. We, in fact, offered to run the local service. We put in a very carefully worked out business case to provide what we believed was a better service to the local population. The actual cost of that service was some £3 million less than the local Health Authority eventually paid to the Trust to provide what is still seen by local people and local GPs as an inferior service. I have to point out that in putting forward that bid we knew that there would be no surplus in it for St Andrew's Hospital but we calculated on the basis of charging exactly what it would cost to provide it. We did that because St Andrew's believes that it is a local Northamptonshire based charity whose objectives are to provide mental healthcare to the people of Northamptonshire and because all of us had come from the National Health Service and felt an obligation to try and provide and improve the local services. I have to say the bid was not even looked at by the Health Authority. It remained on the Chief Executive's desk. I would be more than happy for you to try and verify that with anybody locally, including local GPs or, indeed, of course, the consultants concerned.

2. The second item I wish to comment upon is the response you got from Martin Brown when he asked about the involvement of the independent sector on his External Reference Group. Mr Brown may be being strictly truthful but he was at the very least giving misinformation and being misleading and I am not sure was entirely open about what happened.

In point of fact I went with Caroline Quest to see Martin Brown and he indicated that he would ask Graham Thorncroft for a representative from the sector to be included on the External Reference Group or one or more of its working parties. At no time did he invite written submissions, nor do I believe in the process that I had heard took place, would they have been considered. Whilst I do not think it is a terribly important point, I think it is important to know that he was not being entirely honest with the Committee.

3. The third point, and perhaps the most important one you asked by colleague Dr Rob Jones, whether the College had a view on the regulation of therapists and counsellors. I have had the opportunity of discussing this with many colleagues both at the Royal College of Psychiatrists and, interestingly, with William Bingley the Chief Executive of the Mental Health Act Commission who was there in support of his colleague. My own view is that this will require Government regulation. There probably needs to be registration of the titles of Psychotherapist and Counsellor with a recognition that people who wish to use these titles should be, in some way, state registered presumably via one of the accreditation bodies such as the BACP, the Institute of Psychoanalysis, the Institute of Analytical Psychology etc. There are many such bodies but most of them are very reputable. There clearly will then still be an unregulated sector and it would, I believe, be impossible to fully regulate this as anybody could set themselves up in practice using a term that was outside whatever regulation Government had currently put in place. So for instance, taking a physical example, if the physical therapist were to become banned or become registered to prevent confusion from physiotherapists, somebody could then call themselves a physiological therapist, etc, etc. What perhaps would be important would be to ensure what titles were registered, to let the public then know, to have a central reference point so that the public if they were referred to somebody could ring up that reference point and say, "I am being referred to Mr X, I want to check whether or not they are appropriately accredited and registered". If they were not that member of the public could, of course, decide for themselves whether or not they wish to go to somebody who was not so accredited and approved. There is the other side that sometimes innovation, of course, comes from people providing just such services and I do not think it is right that we should totally restrict the public's right to choose where it goes.

19 April 1999

THURSDAY 22 APRIL 1999

Members present:

Mr David Hinchliffe, in the Chair

Mr David Amess
Mr John Austin
Dr Peter Brand

Mr John Gunnell
Mr Robert Walter
Audrey Wise

Memorandum by the Advertising Standards Authority

THE REGULATION OF PRIVATE MEDICINE: COSMETIC SURGERY (PM 14)

ADVERTISING STANDARDS AUTHORITY

The ASA supervises the advertising industry's system of self-regulation; promoting and enforcing the highest standards in all non-broadcast advertisements. It operates independently of the Government and the advertising industry and seeks to ensure that everyone who commissions, prepares and publishes advertisements in a non-broadcast media observes the British Codes of Advertising and Sales Promotion, ("The Codes"). Current compliance levels stand at around 97 per cent for press advertisements, 98 per cent for poster advertisements and around 85 per cent in direct mailings. A short briefing paper which outlines the Authority's role and remit in more detail is attached.¹

COMMITTEE OF ADVERTISING PRACTICE

CAP is the industry wing of the self-regulatory system and is responsible for writing and enforcing the British Codes of Advertising and Sales Promotion. CAP comprises 21 trade and professional bodies representing all sectors of the advertising industry. As part of their commitment to the Codes, the CAP provides a free and confidential pre-publication advice service to advertisers, agencies, publishers and others. The organisations that make up CAP also support the ASA by providing various sanctions that may be used against those who mislead or offend in their advertisements.

THE RULES

In common with all areas of consumer vulnerability, the ASA keeps a close watch on cosmetic surgery advertising. Complaints about such advertisements are generally considered under the Codes' rules that advertisers must hold adequate documentary evidence to support any claims that are capable of objective substantiation; that advertisements should not exploit the credulity, lack of knowledge or inexperience of consumers; and that no advertisement should mislead by inaccuracy, ambiguity, exaggeration, omission or otherwise.

COSMETIC SURGERY ADVERTISING

Because advertising is a highly visible and open form of communication it tends to act rather like a lightning conductor, and is frequently blamed for all manner of social ills—from road accidents through to unhealthy diets or anorexia nervosa in young women—while arguably more influential factors such as social and family circumstances, peer pressure, and the editorial content of the media are overlooked.

Over recent years a number of press articles have reported on people who have lost money to private clinics or who have suffered as a result of their poor surgical procedures. Such problems are generally dealt with by Local Authority Trading Standards Departments or by appropriate medical bodies such as the General Medical Council. Ann Clwyd MP, as you know, has tried on a number of occasions to introduce a Private Members Bill to ensure that private clinics are adequately licensed and regulated. However, as the enclosed editorials from recent ASA Monthly Reports indicate,² there appears to be very little in law to prevent the problems caused by unscrupulous clinics.

The ASA is, of course, concerned solely with the content of advertising material and its remit does not extend to advertisers trading or clinical practices. Telephone conversations or consultations with sales or medical staff fall outside our scope.

¹ Not printed.

² Not printed.

22 April 1999]

[Continued

COMPLAINTS

In part because the Authority is very active in this sector, most cosmetic surgery advertisements initially appear entirely acceptable under the Codes. Generally it is only as a result of detailed investigation that problems may be revealed. More often than not these relate to the advertiser's trading or clinical practices, and we have become increasingly concerned at what may be a lack of adequate medical regulation in this area.

Complaint levels over the last six years are as follows:

	1993	1994	1995	1996	1997	1998
Total Complaints	9,603	9,657	12,804	12,055	10,678	12,220
Cosmetic Surgery Complaints	6	23	21	103	84	79
Of which upheld	1	3	4	16	22	18

The dramatic increase in complaints from 1996 is the result of one particular member of the public, Mr Asem Mohammed, who runs a vociferous campaign to "clean up" the industry. He and his colleagues appear to monitor cosmetic surgery advertising across all media and do not hesitate to submit complaints when they spot potential problems.

The are also dissatisfied with the ASA because, in common with all campaigning groups, they seek 100 per cent compliance within the sector with which they are concerned. This is unrealistic given the speed and complexity with which high volumes of advertising are produced in the UK; approximately 30 million press advertisements and 3.8 billion items of direct mail appear in the UK each year. Within this context the self-regulatory system currently delivers a Code compliance rate of around 97 per cent on posters and the press.

As of September 1998 Mr Mohammed's complaints have resulted in 42 upheld complaints, and a further 32 informally investigated breaches of the Codes. However, of these 74 breaches some 17 appear to be duplicates. This is because the advertisement concerned was not amended after the first breach and, following a further complaint from Mr Mohammed, or our own follow-up research, it fell foul of the Codes again leading us to invoke other sanctions.

We have made clear to Mr Mohammed that we shall continue to investigate any of his objections that are justifiable under the Codes. However, we have also asked him to reflect on whether his efforts are misdirected at the symptoms rather than the cause of the problem; advertising is only the visible "front end" of a large industry. For our part, the Authority must ensure that any complaints are well founded and not vexatious. (Some relevant ASA adjudications on cosmetic surgery advertising are attached.)³

CURRENT ASA/CAP POLICY ON COSMETIC SURGERY

Because a number of professional associations exist to represent cosmetic surgeons, including the BACS, the BAAPs, and BAPS, it has proved difficult for us to obtain a consistent view with which to inform our advertising policy. In early 1997 we therefore held meetings with representatives from the Royal College of Surgeons and the General Medical Council in order to discuss the procedures by which surgeons gain accreditation and qualifications in cosmetic surgery. (Many of the informed complaints we receive revolve around claims such as "qualified cosmetic surgeon" or the term "specialist", the accuracy of which is not determinable without a detailed investigation.)

CAP HELP NOTE ON COSMETIC SURGERY

As a result of these consultations the Authority's industry counterpart, the Committee of Advertising Practice, drew up the enclosed "Help Note" in November 1997⁴. This has been publicised and circulated widely to clinics, professional associations, advertising agencies and the media. It was also circulated widely to publishers as an aid to help them determine the acceptability of advertisements submitted for publication. The Help Note is now also being used by the NHS Executive, which is responsible for implementing the recommendations of the Independent Review Group (IRG) on Silicone Gel Breast Implants, as an aid to producing advisory literature for consumers who are considering this type of surgical procedure.

January 1999

³ Not Printed.⁴ Not Printed.

22 April 1999]

[Continued

Memorandum by Mr Asem Mohammed**THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 83)****PAID ADVERTISING**

The rules and regulations in Britain are very strict as regards advertising medical services, but at the same time they are ambiguous and the public can easily be misled. An individual doctor or surgeon cannot advertise because that comes under personal promotion which is unethical. However, an institute, a clinic or an organisation can advertise offering any and every type of medical assistance. These are primarily commercial enterprises, invariably run by business men, not medical professionals. In the case of cosmetic surgery, they enticingly offer instant service without the need for referral. Some clinics are extremely worthy, others charlatan set-ups. And the skill of the surgeon varies enormously—from the very good to the abysmal.

Between the period December 1995 and December 1998 I wrote to the Advertising Standards Authority on 50 different occasions complaining about misleading cosmetic surgery advertisements. The ASA is the independent self-regulatory body responsible for supervising the content of non-broadcast advertisements (press, posters, cinema, Internet and direct marketing) in the UK. The ASA is independent of both the Government and the advertising industry. After investigation, 40 advertisements were found to break the British Codes of Advertising and Sales Promotion.

A number of private clinics are flouting the ASA's rules by re-running advertisements in glossy magazines and brochures and on the internet after they have been condemned by the ASA. For example, in December 1995, the Pountney Clinic, a London-based cosmetic surgery clinic, ran an advert with a caption "Britain's leading hospital dedicated exclusively to cosmetic surgery". In January 1996 the ASA asked for the advert to be withdrawn because it implied superiority. The advertisement in question appeared in the December 1996–97 edition of *Cosmopolitan/She* magazine.

In early 1997, the Nobel Clinic, a Surrey-based hair-replacement clinic, ran an advert that showed before-and-after photographs of a man and stated "... All our clients with thinning, receding hair, or even very extensive hair loss, experience NATURAL looking new growth within a few weeks ..." and "established for 15 years in England and Europe ...". In April 1997 the ASA issued an ad alert asking newspapers and magazines not to accept the advertisement. The advertisement in question appeared in several publications including the September/December 1997 edition of *Esquire* and *Men's Health* magazine. Between April 1997 and March 1998 the advertisement also appeared on the Internet.

In January 1998, the Harley Street Wellman Clinic ran an advert with a caption "... Our Consultants are here to help you with proven medical techniques ..." *Consultant* is a title that can be adopted by absolutely anyone, regardless of whether they have medical training at all. It only has significance if the practitioner is or has been a consultant in the NHS, where the title means that they have reached the highest possible grade in a particular specialty (ie plastic surgery or urology). In March 1998 the ASA asked for the advert to be withdrawn. The advertisement in question appeared in several publications including the September 1998 edition of *Esquire* magazine (copy deadline: 14 July, publication date: 13 August).

In February 1998, the Cosmetic Surgery Clinic ran a brochure advert with a caption "... Our patients will have the best advice, will be treated by the best surgeons ..." In May 1998 the ASA asked for the advert to be withdrawn because it implied superiority. Between May 1998 and January 1999 the advertisers continually sent misleading brochures to consumers. Between May 1998 and January 1999 the advertisement also appeared on the Internet.

In July 1996 the Healthwise Medical Group, a London-based cosmetic surgery group, ran an advert with a caption "Surgeons of the highest calibre". In September 1996 the ASA asked for the advert to be withdrawn. Between the period September 1996 and February 1999 the advertisers ignored the ruling and continually sent misleading brochures to consumers. In 1997 the advertisers ran a brochure advert claiming to use "qualified surgeons". In December 1997 the ASA asked for the advert to be withdrawn. Between December 1997 and February 1999 the advertisers continually sent misleading brochures to consumers.

In 1997 the Red Rose Cosmetic Surgery Clinic ran an advert with a caption "... Our aim it to give you a consultation with a properly qualified cosmetic and plastic surgeon ..." In February 1998 the ASA asked for the advert to be withdrawn. Between the period February 1998 and February 1999 the advertisers continually sent misleading brochures to consumers claiming to use a "qualified plastic surgeon". Between February 1998 and February 1999 the advertisement also appeared on the Internet.

The ASA unfortunately are quite impotent regarding extravagant claims from cosmetic clinics and in my many dealings with them I found them to be unable to do anything other than correct the wording of advertisements from time to time. It is common for advertisers to continue running unacceptable claims following an upheld ASA adjudication.

22 April 1999]

[Continued

In a 1997 letter (enclosed)⁵ to the ASA, Professor David Sharpe, President of the British Association of Aesthetic Plastic Surgeons wrote: "Our association is aware of a number of very unscrupulous organisations who advertise frequently in the back of women's magazines . . . Many of these organisations have been responsible for disfigurement and complications in patients".

Examination of Witnesses

MRS MATTI ALDERSON, Director General, Advertising Standards Authority and MR ASEM MOHAMMED, were examined.

Chairman

562. Colleagues, can I welcome you to this morning's session and particularly welcome our two witnesses and thank you for your written evidence and for agreeing to come before us today. I am going to ask you, first of all, to introduce yourselves to the Committee and say about the work that you do. Mrs Alderson?

(Mrs Alderson) Good morning. I am Matti Alderson, Director General of the Advertising Standards Authority. The Authority is responsible for ensuring that all non-broadcast advertising in the UK conforms with the British Codes of Advertising Sales Promotion.

(Mr Mohammed) I am Asem Mohammed. During the last few years I have been campaigning against misleading cosmetic surgery advertisements.

563. Can I start by asking you to say a little bit about why you have been mounting this campaign. Obviously we have met previously. I do not know if you have brought any material with you to the Committee.

(Mr Mohammed) I brought documentary evidence.

564. I think it might be helpful for members to see that during the session. Could you begin by saying why you got involved in this particular area of concern. What motivated your interest in this area?

(Mr Mohammed) I do not have any commercial interests. Many years ago a friend of mine was disfigured after having treatment at a commercial clinic in central London and I decided to complain afterwards.

565. Can you tell us a little bit about the situation, not mentioning names, the circumstances?

(Mr Mohammed) She responded to a misleading advertisement placed by Transform Medical Group which stated "we use fully qualified surgeons" and this claim was completely untrue and I decided to complain and my complaint was upheld.

566. Was this as a result of treatment going wrong?

(Mr Mohammed) Yes, treatment going wrong.

567. What kind of surgery was it?

(Mr Mohammed) Nose re-shaping.

568. Can you say a little bit about which publications these advertisements appear in?

(Mr Mohammed) Many women's magazines: for example, *Cosmopolitan*, *Vogue*, men's titles, *Esquire*, *GQ* and also direct mail brochures and it is even on the Internet now.

569. You perceive your concerns to be primarily with the Advertising Standards Authority. Have you pursued your concerns with editors of some of the magazines? If you could mention some of the magazines you would see these advertisements in for those of us who may not necessarily read women's magazines.

(Mr Mohammed) For example, *Cosmopolitan*, *Vogue*, *GQ*, *Women's Journal*, *Elle* magazine, all of them.

570. So the mainstream women's magazines?

(Mr Mohammed) Yes.

571. Have you pursued your concerns about these advertisements with the magazines themselves?

(Mr Mohammed) Yes, I did. Many years ago I wrote to the Managing Director of the National Magazine Company saying, "You accept misleading advertisements and you should stop this", and he was very rude and I decided not to correspond with him again. They only accept these advertisements due to commercial reasons. In my opinion anyone can pick up the phone and start advertising tomorrow morning.

572. So you feel that you have had no appropriate response from the editors and therefore your campaign has been geared to the ASA?

(Mr Mohammed) Yes, the Advertising Standards Authority make very good decisions, but, with all due respect, in my opinion the system does not really seem to work because, for example, if a company is told to remove a claim, even after one year or two and a half years the same company continues to send out the same material. That is preposterous, is it not? What is the point in complaining?

573. Can you give examples where you have complained and where the complaint presumably has been upheld?

(Mr Mohammed) In my memorandum I gave you some examples. The Advertising Standards Authority in the past have issued ad alerts (it is called a number 2 sanction) where they write to these publishers asking them not to accept these advertisements. The ad alerts result in failure. The same misleading advertisements carry on appearing for some reason.

574. So even though a complaint is upheld, this makes no difference and one assumes that people are enticed to go to clinics where claims are made that are incorrect in your view?

(Mr Mohammed) Of course. Some of the claims are completely preposterous, like the words "leading cosmetic surgery group". They do not provide any

⁵ Not printed.

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Chairman Cont]

substantiation whatsoever. When the ASA writes telling them to withdraw the claim, they should, but, with all due respect, they do not and they carry on sending out misleading advertisements to consumers. I think consumers are being ripped off by these commercial clinics.

575. Is it your view that the problem relates to the lack of power within the ASA rather than the lack of the ASA taking this matter seriously?

(Mr Mohammed) They do take the matter seriously. They have investigated all my complaints and that is very good, but they do not really have the teeth to control the complete industry.

576. Do you see that this necessarily has to be an issue that relates to the ASA or is it something much broader that relates to the lack of regulation of these companies?

(Mr Mohammed) According to the Consumers' Association the complete system is flawed. Many years ago they criticised the Advertising Standards Authority. I do have the press release with me if you would like to see it. They said the complete system does not really seem to work.

Mr Walter

577. I wonder if I could perhaps put some of these points to Mrs Alderson. You have heard what Mr Mohammed has said. Why has it taken so long for misleading advertisements to be withdrawn or amended?

(Mrs Alderson) First of all, Mr Mohammed has been very helpful to the ASA as have other complainants in this special sector and others who have a particular interest in the sector. Mr Mohammed, like other complainants, does not have a full picture. The ASA conduct quite a lot of research itself. In recent months we have done about six weeks-worth of research on cosmetic surgery advertising. We have looked at all cosmetic surgery advertisements and the majority of them have not presented any problems. Those where we have sensed that there might be a problem in proving claims we have written to, and in the last three years we have taken up about 200 complaints of different kinds, the vast majority from Mr Mohammed. Up to about 92 per cent of complaints in a year come from Mr Mohammed because he is concerned about it and does keep it under review and writes to us regularly to tell us about it. So that is very useful to us. I think the root of the problem that we perceive is actually not advertising, it is what is happening inside the clinic and we have no control over that. In fact, to some extent we are filling a bit of a vacuum by trying to talk about that in public and by trying to issue ad alerts and issue help notes. The truth is that nobody concerns themselves with what controls happen inside the clinics themselves. The basic relationship that exists between the doctor and the patient is not something that we can do anything about. We can, of course, do things about claims like "qualified" and "fully qualified". I personally, and my council, do not know how to define those claims and there are no medical authorities defining those claims for us. So again we have tried to go in and fill a bit of a vacuum.

578. Let us say you have a complaint from Mr Mohammed or others and the complainant says, "This advertisement that I responded to was actually misleading" as either the clinic could not do what they said they could do or they were not qualified people that they saw and you uphold that complaint, what happens then? The concern is that you uphold the complaint but the advertisements continue to appear. What powers have you got to make sure that from next month's issue of whatever magazine that advertisement does not continue to appear?

(Mrs Alderson) The way in which self-regulation works is that the industry itself makes up the rules in the codes and agrees to abide by those rules. The vast majority of people in every sector do abide by the code rules and, indeed, all of our research shows that code compliance is running at about 97 per cent, but there can be glitches in it, mistakes can be made. But discounting that, you can get a situation in which advertisers persist in offering advertisements to the media and having those advertisements published and for us, although we are talking about small numbers, that is still a serious business because it undermines the whole principle of self-regulation when that happens. What we can do is much simpler when we are dealing with an advertisement in a publication because the publishers and their trade associations are members of our committee and they agree to abide by the codes and they remove advertisements. It is much more difficult when you get to a position where the advertisers are sending out brochures. We have got to look at it in proportion. An advertiser may have printed 20,000 brochures and we have complained about a text somewhere on page four with one or two words in it that are not right. If it is very serious and it is likely to be detrimental to the public, we would want the company to withdraw all of those brochures, but if it is a matter of interpretation and if the judgement is a grey judgement then we may ask the advertiser to reprint the brochure at the end of the run. All of those things really are subjective and it depends whether or not the ASA Council thinks the matter is serious or not. The danger is that we have no control over whether or not brochures are sent out. We cannot ask anybody else to act as the guardian as it were.

579. Can you not refer that to a trading standards officer?

(Mrs Alderson) We could refer it to trading standards departments, but trading standards are in an even more difficult position in the sense that they have to go to court in order to enforce their views and their judgments. What we are talking about here are very often very subjective claims. For example, what is the difference between a qualified surgeon, a fully qualified surgeon, an experienced surgeon and a very experienced surgeon? What is the difference in the public's terms in those claims that have been made? I am not sure whether or not somebody would decide to go to a clinic because they said they had fully qualified surgeons or very qualified surgeons or very experienced surgeons. Nobody really knows what motivates people at that point to go to the clinic. Is it the claim? Is it because they like the brochure? Is it because they are concerned to go and have cosmetic surgery and this information is available to them? I do not know the answer to that.

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Mr Walter Cont]

580. Could I just go back to the magazine and newspaper advertising for a second because I am concerned about exactly what your powers are and whether there is a need for other regulation. Let us say that a particular clinic was making a misleading claim over a period of six months in *Vogue*. You uphold the complaint and you write to the publishers of *Vogue* and say, "Look, this should not happen". What is to stop that advertiser then going and advertising for another six months in *Cosmopolitan* until you write to them? Is that possible?

(Mrs Alderson) It is less possible than you might think because both *Cosmopolitan* and *Vogue* are part of the self-regulatory scheme. So when we issue information about it this goes to all of them, not just to the single publisher. It is worth pointing out that there is a scale of sanctions that are available to the ASA both through our Committee of Advertising Practice who draw up the codes and also through the ASA itself. The first sanction is refusal of advertising space to a company that does not conform with the codes and that does happen from time to time and in this particular sector it has happened a very great deal over the last few years. The next sanction is if we find the advertisement is continuing to appear to send out an ad alert and to make sure that it goes across the board and that everybody knows about it. If the advertiser, who has principal responsibility for putting together an advertisement and offering it for publication decides that he wants to go ahead with that advertisement and try to get it published, the next sanction is for us to call him into our office to ask the advertiser to make a formal undertaking to us that the claims will not be repeated and that, for example, he will submit his advertisements to us for advance prepublication vetting. Finally, if the advertiser has decided that he is still going to go ahead with publication and is still going to try to flout the rules, we can go to the Director General of Fair Trading who has powers under the control of Misleading Advertisements Regulation to take action in court.

581. Do you think there should be greater preemptive regulation of advertising for medical procedures in the way that is done for those who are advertising pharmaceuticals?

(Mrs Alderson) I do not myself, and my council do not, think that it is necessary to have greater regulation, but I do think that it is necessary to have a greater input from those who are involved in the profession at a much earlier stage. At the moment there is no regulation of what happens in clinics and what surgeons say to patients and what the clinics say to the patients in the way that self-regulation rules exist in our codes for advertising. So if the regulation in the clinics were as strong as the rules in codes of practice for advertising I think you would see a disappearance of these claims because the surgeons would not be allowed to make them and the clinics would not be allowed to make them and that would take care of that, but I think the problem is far deeper rooted than advertising claims, although I do think that people respond to the advertising and that is what shows them where to go to get the surgery. I think the problems are far greater at the clinical practice end than in advertising and far more serious than trying to control advertising, which I think is in

itself well controlled. What we are concerned about and what we have written to the Department of Health about last February and the Department of Trade and Industry (we sent you Chairman, a copy of that letter) is clinical practice and what happens inside the clinics. We are not competent to say what should happen there and we wish we could have some help because I think we all want to operate here in the public interest and we really need the help of those who are involved in the profession to do that at a much earlier stage than producing and publishing advertising.

Chairman

582. As an example, one of the things that we have had raised with us on a number of occasions in this inquiry is the use of the term consultant and you have used terms that could be interpreted in various ways. If you received a complaint in respect of an organisation or clinic saying that patients would be seen by a consultant on their first appointment and then you found out that that consultant was not in any way medically qualified, he was effectively a sales person, would that breach the current regulations? Would it be something that you would do something about?

(Mrs Alderson) Yes, it would be likely to breach the code. It would depend on the way in which that claim was put. For example, if it was clear in the advertisement that you would be talking to a sales consultant (and that is a word the public understand), then there is no reason why you should not use that. What you would find would be a problem under the codes would be using the word consultant to denote doctor in some way when no doctor was involved in the consultation. Of course, we cannot get from any of the medical authorities a clear and strict definition of what those words actually mean, nor do they enforce their use among their members.

583. Do you have any examples of where your organisation has taken action in respect of misleading claims about the consequences of particular interventions, particularly plastic surgery or cosmetic surgery in various ways? I am conscious that we have a dilemma the Committee has discussed before as to whether the state has a role in attempting to ensure that people are not enticed into surgery that could well make their circumstances worse, but in a free society should the state intervene in this way? If you were to see claims being made, people being enticed to go for treatment that clearly would not offer them what really was being implied, how could you act? Have you acted in such circumstances?

(Mrs Alderson) We cannot make judgments about whether or not the clinical treatment is right or wrong or appropriate or suitable for that person. Whether or not it turns out well or badly is something that is outside our control. I think we are hampered to the extent—and I think it is right for us to be hampered because other people have more knowledge and experience—that we deal only with the content of advertisements and the advertisements give information, necessarily they give information that is suited to the advertiser. Advertising is advocacy, so they are not going to give full

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Chairman Cont]

information and I do not believe that advertising could be expected to give full information. It is not a list of do's and don'ts and rights and wrongs about cosmetic surgery, but we would like to see some far more powerful body, perhaps a medical regulator of some sort giving force to judgments about whether or not the clinical practise is good or bad, what happens inside the clinics and flowing from that, what companies can claim about the procedures that they use.

Audrey Wise

584. I understood you to say that you could not expect advertisements to give a list of the dos and don'ts and the pros and cons, is that right?

(Mrs Alderson) Yes.

585. I do not understand why because what we are talking about here is a field which does not simply relate to matters of taste, as it were, it is about things which are invasive on a person. I think that the balance between information and persuasion in a field like this is something which I would have thought you would have wanted to ensure was correct.

(Mrs Alderson) I think we are talking about an area which is deeply concerning. It is deeply concerning to the people who may be harmed by it. I do not think it is possible to see a way in which a company could put every single piece of information into an advertisement or even into a brochure because you would have to be able to predict what was going to happen in each case. I think the relationship that exists there exists not in advertising, which can be tossed away, but between the surgeon and the patient. I think the warnings that come should come in that dialogue between the surgeon and the patient where it is important for the patient to understand from somebody who is qualified to talk to them about it what the negative aspects of surgery might be.

586. It is perfectly possible to put in a brochure the warnings, contradictions. There is information published on drugs to doctors which has the adverse reactions that are possible set out, the contradictions for the treatment. I do not see why that should not be put in brochures. I do not think that in this particular field you can describe an advert as really honest unless it does do that. It becomes simply persuasion and seduction and in essence is misleading. So I am a bit concerned that you seem to narrow the focus quite a lot. There is the phrase about the whole truth. That is not to say entirely every single thing should be included, but do they put any negative things in. Do they put any warnings? Do they suggest that people see their own doctors first? I do not think it can be described as honest in this field unless it does.

(Mrs Alderson) I think you have touched upon the most essential point when you talked about warnings that go to doctors about drugs. That is true, warnings do go to doctors about drugs because they understand what the warnings mean and they can then convey that understanding to their patient, but I am not sure how you could put contraindications of that kind into a brochure for the public. You should not be misleading by overselling what is likely to be

the consequences of having surgery. It is a serious business. I think it is important that an advertiser should not leave out significant bits of information from any advertisement, whether it is a press ad or a magazine ad or a brochure. Leaving out information is quite different from trying to put every piece of information into any advertisement, which I think is a very difficult thing to do when, after all, you have to keep bearing in mind that they are selling the company's products or their brands or their services and the public realise that they are being sold something.

587. I think in the medical field the public assume that selling is not simply a thing which can be freely done. I think the public assume that there is an element of protection and the existence of your body actually encourages them to assume that there is an element of protection. If you have had a prescription in the last few years then you will know that the patient is given information about possible adverse effects, about cautions and so on and that is in instances where they have actually been prescribed the drugs by a doctor and it could be said, "Well, perhaps it is the doctors's business", but we are talking about a field where self-referral is to a large extent the norm and so the advertising is the key or an important factor in the process and yet you seem to dismiss the information aspect a bit too lightly.

(Mrs Alderson) I would not want to give you the impression at all that the ASA dismiss this lightly. The ASA is very concerned to make sure that the information that is conveyed to the public—just as you are—is good information and is true information. I think that the point here is that the public do know what advertising is about and they do know that they are being communicated with when a company wants to sell them something. That kind of commercial communication is only one form of the communication that they will hear if they decide to go ahead. They go along and the surroundings will communicate something to them and then the people that they talk to who are going to talk to them about the clinic and about the business arrangement will communicate something else to them, but in my view the most important communication comes from the person that is going to be carrying out the surgery and everything else stems from that. No matter how good the brochure is, no matter how real the claims are and no matter what kind of controls you put on advertising, they are not going to solve the fundamental problems that are going on inside the clinics if people are being maltreated in some way. It is not clear to quite a lot of clinics what is required of them. I am not here to advocate their case, to make excuses for them, but I know that from my point of view it is often not clear what is required of clinics. There is no regulator to tell them. Getting information from the medical authorities is quite difficult and so I think that there is a lack of that kind of communication that would be of fundamental help to the public if only it existed. We could all draw on it. We could all be facing in the same direction when we do draw on it rather than seeing advertising for what it is here, a lightning conductor. If you solve any problems that exist with advertising, and they are small problems, you will not solve the basic problems about patient treatment.

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Audrey Wise Cont]

588. I do not think anyone would say that is the whole story, that is for sure. I am really concerned. For example, in your own evidence there is a paragraph which says that "As of September 1998 Mr Mohammed's complaints have resulted in 42 upheld complaints, and a further 32 informally investigated breaches of the Codes. However, of these 74 breaches, some 17 appear to be duplicates. This is because the advertisement concerned was not amended after the first breach ..." That supports Mr Mohammed's claims that this is not adequate and it is too slow. The 17 which appear to be duplicates seem to me to be the most important 17 and you say it "fell foul of the Codes again leading us to invoke other sanctions". I wonder if you would care to send us a note of the 17 and what the other sanctions were?

(Mrs Alderson) I would be very pleased to send you a note.

(Mr Mohammed) First of all, the real figure is much higher. If you respond to this same advertisement and complain about the same advertisement after six months, 12 months or even after two years, the Advertising Standards Authority issue different complaint numbers. Seventeen is extremely low. I would not be surprised if the real number is probably over 50. Nearly every week I write to the Advertising Standards Authority saying, "I once again object to the following complaint. Please explain why this advertisement is appearing." The ad alerts, the number two sanction, clearly does not work. Magazines, even after receiving ad alerts, carried on accepting these misleading advertisements. In April 1997 the Advertising Standards Authority issued an ad alert. After six months every magazine under the sun carried the same advertisement. After one year one of the magazines was still carrying the advertisement. So clearly ad alerts do not work. The number one sanction, negative press coverage, also does not work. Only large companies like Sony and British Telecom are mentioned in the media. These small clinics are never mentioned in the media. They publish something like 40 or 50 cases and, according to my information, no company has been mentioned in the press shortly after an upheld adjudication. So this is kind of misleading. In my opinion ASAs sanctions do not seem to work.

Dr Brand

589. Mrs Alderson is obviously not happy about the situation. You say that it happens a great deal. Advertising is not just advocacy for a firm, it also is done to create a demand and the best way to create a demand is to make great claims for a service you are advertising. In the pharmaceutical industry no claim can be made until it can be substantiated and presumably you work closely with the Medicines Control Agency so that you know what guidelines you can follow. Likewise, I do not think anyone in the financial sector can advertise guaranteed prosperity and every advert there has got to have a rider saying, "Investments can go down as well as up and you can lose your house". I think that is a pretty substantial caveat to the advertising. I have never seen a cosmetic surgery advert saying, "Your life maybe put at risk and you may well be disfigured for

life". Is your problem that you have not got the equivalent to the Medicines Control Agency to refer to or is your problem that you find the problem too difficult and therefore you rely on Mr Mohammed and his arduous work to keep you on your toes? I share Mr Mohammed's concern that clearly one sees this year in year out.

(Mr Mohammed) I do have documentary evidence I would be more than happy to show you. They do not work at all.

Chairman

590. The impression I have gained from what you have said is that your concern is more with the regulation of the clinics themselves, I understand that, rather than improving your ability to address some of these issues. Your point was that we need to get in the front line of these clinics medically qualified people, but these medically qualified people will still have an in-built incentive to induce, mainly women, into operations of the kind that Peter has described that they may not need. How does that improve the situation that we have at the moment because I do not understand?

(Mrs Alderson) Can I distinguish between getting people to come along and have operations and advertising. I think you went to the heart of the problem by touching on the medicines regulations, the Medicines Control Agency, the Financial Services Act. Those activities are all regulated by law. They all have very clear rules that they have to follow, not just to do with advertising but prescriptive rules to do with how they deal with customers and, in the case of medicines, with patients. This area does not have those kind of rules and that is why the ASAs find it very difficult to fill a vacuum that we are not equipped to fill with arbitrary decisions about whether or not a word means one thing or another. What we would want to see is far more regulation at the bottom end of the pile rather than at the public end of the pile.

Dr Brand

591. Sorry, what do you mean by that?

(Mrs Alderson) Regulating what people can say is not going to be nearly as effective as regulating what people do to patients.

592. Can I just expand on that slightly because you have said three times now that the regulation ought to be at the doctor-patient level and at the what happens to a patient as a result of intervention by a doctor. The doctors do not make the claims. In fact, they are professionally debarred from direct advertising. The claims are made on their behalf by the host clinic or very often by the employing clinic. Clearly, it is illogical if you are saying that the control has got to be at the doctor level rather than at the organisation level because most clients of these clinics see their contract with the clinic and the claims that they are reacting to and responding to are not made by the consultants or the doctors but by the clinic. Do you not think that there ought to be something that holds the clinic to account so that the clinic can then control what happens at the patient-doctor level?

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Dr Brand Cont]

(Mrs Alderson) Yes, I agree with all of that. I am not saying for a moment that the clinic should not be controlled too.

593. What representations have you made to get some clarity into this?

(Mrs Alderson) We have written to the Department of Trade and Industry, we have written to the Department of Health and we have written to the General Medical Council.

594. And what has their response been?

(Mrs Alderson) Their response has not been all that positive at the moment, but we are continuing to talk to them. We have continued to monitor the situation and to let anyone who is involved in this know what we have been doing, but we are at the communications end of it rather than the regulation end of it.

595. But surely you are regulating communication and you are saying your problem is that you cannot regulate this communication because there are no good enough guidelines for you to apply your own guidelines.

(Mrs Alderson) We can regulate the communication, but what we cannot do and what would be unreasonable to do is to use our organisation as a substitute for framework legislation that should be there to control both doctors and clinics.

Mr Austin

596. We are dealing with areas of false claims for particular procedures and also, as Mrs Wise has pointed out, risks and possible outcomes. Given that there is not a regulatory framework like there is with IMRO or with financial services, the National Institute for Clinical Excellence is about to be up and running and presumably may lay down guidelines in areas about particular techniques and forms of treatment. Do you think that there is a role here for the ASA to require advertisers to draw people's attention to any guidelines that NICE may lay down?

(Mrs Alderson) I think they would have to be more than guidelines. The ASA requires companies in all sorts of sectors to follow the law to the letter because their advertisements cannot be published unless they do that. So in the financial services area there are rules that they have to follow that are laid down by law. I think we would want to see something rather tougher than general guidelines. We will work alongside anyone who wants to produce guidelines that protect the public because we have to and are determined here to operate in the public interest, but I think in an area like this which has not been properly regulated throughout its history, since the advent of clinics offering surgery to the public, there has to be something stronger than a general guidance note. We have issued guidance notes and they are certainly followed, but I do not think they are strong enough and we are not there to deal with core problems.

(Mr Mohammed) Perhaps the Director General will explain to the Committee why ad alerts in the past have failed. I have documentary evidence here to show they do not work. When they write to publications saying, "Please do not accept this

advertisement because it is misleading," it seems the publishers pay no attention to their correspondence. The number two sanction simply does not work.

(Mrs Alderson) I am not quite sure what a number two sanction is. We talked earlier on about publicity. Publicity is not a sanction, it is a deterrent. It deters people from doing it because they think they will get bad publicity. The ASA cannot control where that publicity arises, who publishes it. In terms of the ad alerts, those are sent out to a large number of organisations that publish this kind of advertising. I can produce a considerable amount of evidence (and we shall certainly do so afterwards) to show where they do work. There have been areas in which they have not worked and this is disappointing because the companies when they get the ad alerts, when they get the guidance notes, know what is required of them. In the last year we have called in three companies to make formal undertakings to us as a result of ad alerts not working. Those companies have given us formal undertakings. They have also sent their advertising to us for pre-vetting. We have found nothing wrong with two of the company's published advertising since then and the third company has gone out of business.

(Mr Mohammed) That is not true.

Chairman

597. Do you want to respond to that?

(Mr Mohammed) Mrs Alderson's comments are completely unfair. The Transform Medical Group only a few weeks ago was sending out literature to consumers saying "Transform—the world's leading cosmetic surgery group". So they have broken the undertaking with the ASA.

598. Why does that break the undertaking? Obviously Transform will be speaking to us later on. Why does that break an undertaking? Can you expand on this particular point? Obviously it is relevant to our discussions.

(Mr Mohammed) According to my information, the Advertising Standards Authority did have meetings with the Transform Medical Group and they assured them and that they will not be sending out misleading information to consumers again. I believe this meeting was held last year. Only a few weeks ago I received misleading information through the post saying that Transform was the UK's leading cosmetic surgery group and this claim is completely unacceptable. Over one year ago they were told to remove the claim.

599. Is that correct, Mrs Alderson?

(Mr Mohammed) I have the documentary evidence in front of me¹.

(Mrs Alderson) This is an interesting point. I would want to hear from Mr Mohammed about this. We do what is called "mystery shopping" in this area, that is where my colleagues phone up clinics and ask them to send brochures to us. We do have the brochures that are sent out. In some cases brochures that are sent out are running down, as I explained earlier, to

¹ Note by witness: In February 1998 the Transform Medical Group was told to remove the claim "Transform are the country's leading cosmetic surgery group". In March 1999 the clinic was still making the same unfounded claim.

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Chairman Cont]

the end of the print run. In other cases what appears to have been sent to individual members of the public are not being sent to us.

Mr Gunnell

600. I would take it from what Mrs Alderson said about the lack of regulation and the need for regulation that she would welcome this Committee coming to the view that there should be much tighter regulation and specific regulation of clinics, but would it be sufficient just to regulate clinics? Is it not necessary to regulate what goes on in them? First of all, where a company advertises and implies that a person with medical qualifications will be present to advertise on the treatment and to carry out the treatment, have we not got to be sure that that does happen and that a person cannot get away with just describing themselves as an advertiser and make sure they have to have the appropriate medical qualifications? Have we not also got to be sure that if they use apparatus which can damage people, e.g. lasers, they are qualified to use that apparatus? Have we not also got to make sure that the apparatus itself is in working condition and that people have the necessary safety glasses to wear when it is in use? Is it not necessary to have very much tighter regulation of all these things in order to control the sort of practice which goes on at the moment?

(Mrs Alderson) We would find that enormously helpful, I must say and it is what we have been calling for now for some years.

601. So you would welcome this Committee coming to that conclusion and requesting the Department of Health to bring in tight regulation of clinics and on what goes on in them and those who practice in them to make sure that the public get what they think they are getting from the advertisements?

(Mrs Alderson) Yes, we would like to see something perhaps akin to a medical regulator who would have powers over what happens to the public.

602. But it does need the three different elements all to be controlled, does it not? It needs the clinic and the procedures in the clinic, it needs the qualifications of those who use the apparatus and it also needs regulation of the apparatus itself to make sure that it is in working condition and is delivering accurate frequencies, if it is a laser?

(Mrs Alderson) Yes, I agree with that. I think that the clearer it is to those involved with patients, patient care, advertising, promotion what they can do and cannot do and what they can claim and cannot claim the better it will be for the public and the easier it will be for regulators like the ASA to do our part of the work in relation to the content of advertisements.

Mr Austin

603. We have received evidence that adverts contravene your Code and yet continue to appear. There are two offenders here. One is the clinic who is advertising and the other is the publisher of the magazine. Mr Mohammed has told us that magazines continue to publish misleading advertisements. I would like to ask you whether you

believe the sanctions both against the advertiser and the publisher of the magazine or whatever are sufficient. I would also like to ask you about another area which I gather you are also responsible for, which is advertising on the Internet and whether this is posing even more problems in terms of regulation and control and whether there are any sanctions, not only against the clinic or the advertiser but against the Internet service provider. How can that be regulated?

(Mrs Alderson) Yes, advertisements have appeared again which should not have appeared and short of having what would necessarily be a policeman in every corner stopping everybody speeding, the ASA cannot stop or prevent the 30 million press advertisements that appear every year or the three billion mailings and brochures that are sent out every year. We must rely on companies to some extent, first of all, to come to us and, secondly, that the sanctions that exist are operated properly and that they are proportionate to what should be done with advertising claims.

604. Mr Mohammed would suggest that the sanctions are not sufficient because the adverts continue to appear even after you have made a determination.

(Mrs Alderson) Occasionally advertisements appear, but we are not talking about large numbers of advertisements at all and we are not talking about large numbers appearing. Mr Mohammed is that policeman on every corner. We are looking at 30 million press advertisements every year in a wide range of sectors. Can I come to your point about the Internet. Because we are very keen to operate in the public interest and to look at every new sector of media that comes up, we have been trying to work with Internet service providers now for the last couple of years. Of course, nobody can control what goes on the Internet. Governments are trying to do it all over the world and I am afraid the ASA has not been any more successful than them. What we do think is likely to be effective is self-regulation where companies decide to regulate what they put into their web sites on the Internet and we have been talking to those service providers. We are in the process of trying to put together an e-advertising scheme which the industry would then take on from there, producing what we hope will be something like a safe trading zone for consumers where they will feel confident that if they talk to companies in that area, they are dealing with people who want to abide by codes of practice and abide by the rules. I have to say that that is as much as anything enlightened self-interest because if your advertising is not credible then people are not going to buy things from you. I think there is quite a good impetus on the part of companies and service providers to go along with that scheme and to put it into place. What is impossible to do is to get advertising off the Internet if companies decide that they do not want to remove it and there is nothing that the ASA or the Government or any other authority will be able to do about that. We have given a good deal of advice to companies using the Internet, not just in this sector but in other sectors too and as usual the companies

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Mr Austin Cont]

that want to appear to be credible take the advice and work well with it. The companies that do not care about it do not come to us in the first place.

Audrey Wise

605. You have indicated, Mrs Alderson, that you would like to see stronger regulation over various aspects of cosmetic surgery. Would you like to see yourselves having strengthened powers regarding the advertisements or do you think everything has to be done by these other means?

(Mrs Alderson) Almost every organisation would like to have stronger powers, but in this particular case I think that the powers that we have are proportionate and appropriate to what we can do and what we are able to do. It would make our case very much stronger in dealing with companies if the basic legislative framework was in place because this is one of the few areas in which we deal where the framework legislation does not exist, and the ASA is always much more effective when it is dealing with framework legislation and backing it up. I do not think that we need any further powers. I think that the powers that exist to us would be sufficient if they were underpinned by better framework legislation and much clearer rules for the companies involved.

606. Some such recommendations might emanate from this inquiry and no doubt you would welcome that. Your evidence tells us that the Codes under which you operate require the advertisements to be "legal, decent, honest and truthful, socially responsible and prepared in line with the principles of fair competition". I am very interested that it is honest and truthful, clearly emphasising this aspect greatly and I am very interested that it includes the concept of social responsibility. Can you tell us how you look at the concept of social responsibility in the context of advertising cosmetic surgery?

(Mrs Alderson) The division between honest and truthful is that you cannot, because the codes are read in the spirit, make true but misleading statements; it has to be honest as well. So when you talk about nine out of ten people believing something, you cannot have a sample of ten unless you tell the public that that is the case. What we are looking for on social responsibility is to ensure that the advertisers are not saying anything that is unsupported, unsubstantiated that suggests to the public, for example, that they are going to live a longer life because they have an operation or that something is going to happen to them that is going to change their lives beyond all measure, nor that they are going to be treated by people who are not qualified in the way that they say they are qualified.

(Mr Mohammed) The problem which concerns me is when the Advertising Standards Authority writes to a company saying, for example, they should remove the claim "fully qualified surgeon", even after 2.5 years or 12 months they carried on sending out the same literature saying, "We use fully qualified surgeons". Surely this proves there is something wrong with the system. I would like to point out again that Mrs Alderson's earlier figure of 17 duplicates is incorrect. The real figure is far higher.

607. In any case, I regard 17 as being an extremely impressive figure.

(Mr Mohammed) To be completely honest with you, I think the real figure is easily over 50.

608. But the fact that there are substantial numbers of duplicates even on the ASA's own evidence is significant. Let me go back to "honest and truthful and socially responsible". I am interested in what they do not say as well as what they do say. We have explored this to some extent. I would like to follow the point made by Dr Brand when he said that where the thing is regulated you have to say you may lose your house, etcetera. Would you be entitled to say that cosmetic surgery advertising is not socially responsible and is not honest and truthful unless it carries a caveat such as "All surgery carries an element of risk"?

(Mrs Alderson) I do not think the ASA could actually say that because there is no legislation that says that we can say so, unlike the Financial Services Act which requires that. This is why we have sought support from legislators in order to do that.

609. I understand that, but how can it be regarded as truly honest and truthful and truly socially responsible unless it carries such a caveat? Are you not looking at your powers, entitlements and responsibilities very narrowly? What is not said can be as important as what is said and it is undeniable as a statement of plain fact that all surgery carries an element of risk. So what would stop you putting a requirement that that had to be said and then let them challenge you, let them say you are going beyond your powers?

(Mrs Alderson) I do not think that it is something that the ASA should or would be entitled to do unless there is legislation requiring it. In addition, I think that the public on the whole will understand—because they are not naive about advertising and they are not naive about surgery—that any surgery must carry an element of risk. I am not sure what it would achieve putting it into a brochure, but perhaps you have been told differently.

610. But the emphasis is on the safety of this. People are encouraged to think that they can be made beautiful safely and people reading these specific advertisements and acting on them are in a rather anxious state on the whole, otherwise they would not be considering subjecting themselves to surgery. Do you not think you have got a special responsibility there and why not seek to test out the limits of what you can do? You admit all surgery carries an element of risk. In that case, why not tell them they have got to say this? You might think it is superfluous, but perhaps the person reading the advert is suppressing that information. We all know that cigarettes carry an element of risk, but it does not mean they do not have to say it. The legislation in which you operate requires you to ensure that they are socially responsible and that they are not only honest, not only truthful, but honest and truthful.

There must be some reason for that extra emphasis. You seem to be extremely narrow. You have not ever tested out the social responsibilities aspect, for instance.

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Audrey Wise Cont]

(Mrs Alderson) I think it is worth just distinguishing between the rules that we are operating under because I am afraid they are not legislative so we cannot require people to do things. We do not operate under legislation. These are voluntary, self-regulatory codes of practice.

611. Right.

(Mrs Alderson) If the Government are able to give us a much stronger basis on which to make that requirement we would be delighted to make the requirements that the Government want, as in the Financial Services Act.

612. So would you like stronger powers? I asked you would you like stronger powers and you said "no", you do not need them. Then you tell us that it is voluntary and, therefore, you are severely limited.

(Mrs Alderson) The point is these are not stronger powers for us, these are stronger powers that come out of legislation, not out of our code of practice.

613. Would you like there to be a greater element of compulsion?

(Mrs Alderson) I think there should be a greater element of compulsion in controlling the clinics and the advertisers and the surgeons within the clinics, yes.

614. Would you like to have greater powers of compulsion as the ASA?

(Mrs Alderson) No, I do not think it is necessary for the ASA to have greater powers of compulsion. If they exist in law then it is a requirement, as our code says, that advertisements have to be lawful.

615. Finally, you say in your evidence: "For our part, the Authority must ensure that any complaints are well founded and not vexatious". This is in the context of evidence which makes it very clear that Mr Mohammed's efforts are by far the greatest element that you have to deal with in this particular field. Tell the Committee, please, how you would define "vexatious" and why you make that particular statement in the context of a paragraph which is about things which you have made clear to Mr Mohammed?

(Mrs Alderson) In fact we make that kind of statement in relation to quite a lot of evidence that we give to different organisations, departments, both here and in Brussels because it is a requirement both of the law here and of the legislation that we all must operate under that we should work in proportion to the issues that we are operating with. What I am very concerned about is that we do not get very many complaints from members of the public about cosmetic surgery advertising in relation to treatments that they have had personally. We are not hearing from individuals who have been treated in the clinics. I would encourage that a little bit more so that we can see whether or not there is something that we should be doing here.

616. May I suggest a possible reason for that as being if a person responds to an advertisement and gets given treatment which proves disastrous, there is scarring, pain, ineffective treatment, things like that, do you think that person is going to be in the frame of mind which leads him or her to write to the ASA? I would think they would be reckoning up whether they could afford to sue or not.

(Mrs Alderson) I think that is right.

617. Do you not think that it is a field in which the actual victims are less likely to make personal complaints and that it is more likely that somebody like Mr Mohammed or an organisation like the Consumers' Association, which sends its researchers in incognito and then tells the world what has happened to those researchers, will make complaints? Do you think that is a lot more likely?

(Mrs Alderson) I think it is very much more likely. I think that the people who feel that they have suffered as a result of cosmetic surgery are probably not concentrating on advertising. It is a pity that we do not hear from these people who feel disaffected, it would help us to know what their problems are with the advertising, but of course they have far more serious issues to concern themselves with, which is why I go back to the point that I think we need some kind of medical regulator in this area. We need somebody who can provide full advice, which we talked about earlier, full information, which does not come out of any advertisement and is unlikely to come out of any advertisement. There is no source for people to go and get proper, full information. There is no single source that they can complain to if something goes wrong.

618. What sort of relations do you have with the Consumers' Association which does such a lot of work in this field by sending in researchers incognito?

(Mrs Alderson) The Consumers' Association keep us informed very regularly of the different work that they do in this and in different sectors of advertising.

619. What do you do with their information?

(Mrs Alderson) We either investigate complaints, if they make formal complaints, or if they alert us to something in any sector that seems to be going wrong that they have noticed then we undertake research in that sector.

620. Has that been productive and, if so, what has been the result?

(Mrs Alderson) It is very often very productive, yes indeed. They have made a lot of very good reports to us over the years about things that they have spotted or things that have come up in their postbag that they hear through their members.

(Mr Mohammed) Mrs Alderson keeps talking about a medical regulator but there is one, the General Medical Council. I do not understand why she keeps saying that we should have a medical regulator because there is one at the moment, the General Medical Council. Consumers can complain. If a patient is disfigured or if a surgeon has lied during a consultation then the patient should file a complaint to the General Medical Council.

621. You mentioned enlightened self-interest at one stage in your evidence, Mrs Alderson. In the code it talks about the principles of fair competition. Would you accept that it would be very difficult for a clinic which wanted to include any negative aspects or warnings in an advert to do so in a context where nobody else is doing it and you are not asking them to do it? Do you not get a driving down there? Should you not be perhaps encouraging social responsibility

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Audrey Wise Cont]

by making it easier for clinics who want to give fuller information to do so without suffering unfair competition?

(Mrs Alderson) We do not make it difficult for clinics to give as much information as they want to give about their own services and their products. There is nothing in the rules on fair competition that would stop clinics from giving any kind of information that they want to give, provided it was accurate.

622. It is very hard, is it not, if some people are operating on the most persuasive but least informative adverts, for the clinic which wants to be more socially responsible to be so? Surely then they would feel that they were suffering from unfair competition because nobody else was including caveats, adverse warnings or anything? Would it not be just about impossible for them to do so? Is it not your responsibility to provide a context in which they all can do that?

(Mrs Alderson) What the codes require them to do is to give information which is not misleading. I think it is important for them not to feel that they are trading at a disadvantage, for example, by being told that one clinic must do something that another clinic is not going to do. That is why you need more than a code of practice if you are going to require health warnings of any kinds in advertisements.

Mr Walter

623. I have two brief questions, one following up on what Audrey Wise has just been talking about. What has perplexed me whilst you have been giving evidence is actually what we are talking about is an advertisement that is the basis of a commercial transaction, it is the first stage of the contract. If people are responding to those advertisements, whether they be in magazines, direct mail or even on the Internet, that does not really matter because if people are responding to them and taking up the services and are dissatisfied with the services then they have a complaints procedure at law. If there is a complaint which is upheld by the courts and the advertisement for which you have some responsibility was part of it then surely that gives you much greater powers to say "this advertisement has to be withdrawn" and if the advertisement is not withdrawn then surely the trading standards department of the particular local authority should be visiting those premises saying "you are continuing to advertise something which you have just been found against in the civil courts"? That is my first point, I would like you to comment on that. I wonder whether you are not as toothless as you seem to be claiming. The second point is that if this Committee were to recommend that the private sector of health care should come under an overarching regulatory body controlling the National Health Service and so on, would you see it as the role of that body to say "if a clinic or a private hospital were to be registered under this regime that this is the standard, this is the advertising standard" and it would be that body that would determine the advertisements and the standard for advertisements rather than your body?

(Mrs Alderson) I think on the first point you raised about the courts, I am not aware of people running to the courts and talking about advertising reports in relation to cosmetic surgery. The fact is that we do not have enough support, legislative support. People are not taking advertising to court. Trading Standards Officers, as far as we are aware, have not taken advertising to court.

624. Do you think that is because the majority of settlements are settled out of court rather than in public judgments?

(Mrs Alderson) I think that may be the case and I think that what you would have in most of those cases would be a commercial relationship or a doctor-patient relationship that could only really be settled directly. In terms of advertising I find it difficult to see how a Trading Standards Officer would feel confident about going to court in relation to some of the claims that we are talking about here. There are very small changes to claims—qualified/fully qualified, experienced/very experienced. It is difficult to see how a Trading Standards Officer would feel able to spend two years mounting a case and taking it to court with the possibility of its being thrown out at the end of it without anything having been achieved.

625. I am very conscious of the time factor and we have other witnesses, but on my second point about a regulatory body, whether it be the Commission for Health Improvement or some other body, looking at the regulation of the whole sector, the public and private sector, registering clinics, would they be the body that should say, "These are the advertising standards," in the same way as they might regulate what a general practitioner could place in his local newspaper?

(Mrs Alderson) My recommendation to you would be not, because the ASA already exists and the rules are there and the rules are being followed by the vast majority of companies. So I do not think you need to set up a separate body, a different body, to do that, but I think if you had a body doing the other basic matters which we talked about earlier, you would solve the problems to do with the advertising because it would be clear how far both clinics and doctors were allowed to go in their communications, not just their advertising communications but all the communications that they have with anyone coming into the clinic.

Chairman

626. Are there any final points that any of my colleagues want to ask? Does either of our witnesses want to add any more?

(Mr Mohammed) Would it be possible to distribute this newspaper article to the Committee?

627. Yes, it would, if you want to. Do you want to add anything in terms of your own evidence?

(Mr Mohammed) The only thing I can say is that the former Director General of Fair Trading, Lord Borrie, QC, agreed with me that there is a problem with the Advertising Standards Authority. Thank you for seeing me.

628. Mrs Alderson, do you wish to add anything?

22 April 1999]

MRS MATTI ALDERSON AND MR ASEM MOHAMMED

[Continued]

[Chairman Cont]

(Mrs Alderson) I am very pleased to have been able to come and talk to the Committee today. I think it is very important that if we are all operating in the public interest we should be facing in the same direction. And I hope that we will be able to put perhaps a page or two to you adding to this to show what is happening right at the moment.

Chairman: We would be very grateful to you for that.

Mr Austin

629. Could Mr Mohammed verify what he said Lord Borrie had said and could he supply us with evidence of that?

(Mr Mohammed) Of course I can. I recently met Lord Borrie at the House of Lords. He is the former Director General of Fair Trading. In fact, he wrote to the Consumer Affairs Minister, Dr Kim Howells, on my behalf. I will be happy to send you the letters, if it is appropriate.

Chairman: That will be very useful. May I say to both of you we are most grateful. Thank you very much.

Memorandum by the British Association of Aesthetic Plastic Surgeons of England

PRIVATE PRACTICE (PM 30)

The British Association of Aesthetic Plastic Surgeons was constituted in the late 1970s with the expressed purpose of improving standards and particularly training in aesthetic plastic surgical techniques and practice in the UK. Over the ensuing 20 years it has grown, both in membership and influence. The Association is now based at the Royal College of Surgeons. It has approximately 120 active members, all of whom are fully accredited Consultant Plastic Surgeons with experience. The Association organises and runs a number of training courses within the UK. This is a role which has assumed greater importance as changes within the NHS has progressively reduced the amount of aesthetic surgery done under its umbrella and, therefore, reduced the opportunities for surgeons in training to learn this very important aspect of plastic surgical practice.

Aesthetic, or cosmetic, plastic surgery has been practised in various forms since the 6th Century BC. In the late 20th Century, however, it appears that an increasing number of individuals are seeking advice and surgical assistance with various aspects of their physical appearance. In parallel with this increasing demand has come an increasing number of practitioners wishing to work in this area and, in addition, a burgeoning number of "private clinics" whose sole motivation is financial. Since the potential rewards are great, a number of these organisations "employ" doctors who are inadequately or improperly trained to carry out work for them. The majority of their patients are frequently gained through seductive advertising rather than by recommendation or direct referral from other doctors. Many employ "lay counsellors", some of whom are nurses, but many of whom are simply sales people, who "advise" potential patients on operations which may be suitable for them. Frequently the patients do not meet the doctor who will carry out their surgery until immediately prior to their operation, having already paid for the procedure. Such organisations are of great concern to the BAAPS. They prey on a gullible public and their standards of practice both in terms of premises and personnel often fall far below that which one might reasonably expect. This is not a "turf dispute" as it is often portrayed between "the establishment" and others but a general concern for the well being and safety of patients. This concern is reflected in the large number of medico-legal claims made against doctors practising in such clinics.

The Association believes that in any governmental review of private practice in general it is important to look specifically at aesthetic surgical practice, particularly within commercially run private clinics. The public have a reasonable expectation that doctors working in this field should be properly trained and presently the only recognised training scheme is the "CCST" in plastic surgery, overseen by the Royal College of Surgeons. The practice of employing lay counsellors to screen or encourage patients towards surgery should not be allowed and all private hospitals should have a properly constituted medical advisory committee, or equivalent to ensure that all doctors working within them are properly and adequately trained in the specialty which they practice.

The British Association of Aesthetic Plastic Surgeons would be pleased to offer any practical assistance that it can to the Parliamentary Select Committee in its deliberations.

January 1999

*22 April 1999]**[Continued]***Memorandum by the British Association of Plastic Surgeons****THE REGULATION OF PRIVATE MEDICINE AND OTHER INDEPENDENT HEALTHCARE
(PM 96)****SUMMARY**

The award of a certificate of completion of specialist training and entry in the Specialist Register of Plastic Surgeons is evidence of supervised training and examination in aesthetic or cosmetic surgery.

On enquiring of the General Medical Council a member of the public will be told only that a surgeon is on the Specialist Register. They will not be told in which specialty the surgeon is registered.

Many patients seeking cosmetic or aesthetic surgery choose self referral.

Some advertisements for commercial clinics offering cosmetic or aesthetic surgery contain statements such as "all our surgeons are Fellows of the Royal College of Surgeons". The public perceive this as being indicative of training and experience. They do not appreciate that this is a basic qualification, in no way indicative of training in this specialist field.

The general public has no way of ascertaining the level of training or experience of surgeons who do not hold NHS appointments.

Some commercial clinics employ lay-counsellors to conduct the initial consultation. Their role may be to increase business for the organisation rather than to ensure that the patient has the most appropriate treatment.

Steps should be taken to protect patients who may be vulnerable. They should be able easily to ascertain their surgeon's training and experience. Initial consultations should only be with an experienced surgeon.

TRAINING

Under the arrangement of Higher Specialist Training introduced by Sir Kenneth Calman, trainees in plastic surgery have to complete a syllabus of training over a six-year period prescribed by the Specialist Advisory Committee in Plastic Surgery of the Joint Committee for Higher Surgical Training of the Royal College of Surgeons. It is the Royal College of Surgeons that are charged with the task of maintaining standards in surgical training and they have delegated the supervision of this to the Specialist Advisory Committees. In years one and two the trainees are required to complete a module on "the principles of aesthetic surgery". In years three and four they are required to complete modules in the reconstructive and aesthetic surgery of the face and lips, the nose, the eyelids, the ears, the breasts, and the trunk and limbs. In addition they are required to complete a sub-specialty module in aesthetic surgery. In years five and six they have the option of continuing with advanced general specialty training which would include further training in aesthetic surgery or they may chose other options, one of which could be further training in aesthetic surgery. After successfully completing year four of their training they are required to sit the Specialty Fellowship in Plastic Surgery run by the Intercollegiate Specialty Board in Plastic Surgery which is similarly constituted to the Specialist Advisory Committee. The scope of the examination is described in the regulations as follows, "the scope of the examination will consist of the principles, practice and basis sciences relating to"—it then goes on to describe all the areas of plastic surgery including—(o) all aspects of aesthetic surgery and (p) knowledge of medical ethics, aspects of informed consent and medico-legal implications of clinical practice. The Intercollegiate Board reports to the colleges of surgeons through the Joint Committee for Intercollegiate Examinations and the Senate of Surgery. Following successful completion of the examination the diploma is awarded by one of the colleges. The Specialist Advisory Committee in Plastic Surgery carries out regular inspections of units in which training is carried out. In recent years there have been restrictions on the volume of cosmetic or aesthetic surgery carried out in the National Health Service though this varies from region to region. The inspecting team will therefore enquire as to the amount of surgery of this type being carried out. If it is judged to be insufficient they will insist on arrangements being in place for trainees to have secondment to the private sector (possibly on day release basis) to ensure adequate training in this area of surgery. In addition that standards are maintained at a high level by the examination is evidenced by the failure of more than 50 per cent of the candidates at the last diet of the examination. It may therefore be seen that the award of a Specialty Fellowship in Plastic Surgery and a Certificate of Completion of Specialist Training in Plastic Surgery followed by entry in the Specialist Register of Plastic Surgeons is evidence of a closely supervised training and a clearly defined standard of knowledge in all aspects of plastic surgery including aesthetic or cosmetic surgery. It should be noted that surgeons from the European Union who have satisfactorily completed training in their own country may also be entered on the Specialist Register.

However, unfortunately, if a member of the public makes an enquiry of the General Medical Council they will be told only that a particular surgeon is on the Specialist Register and they will not be told in which specialty the surgeon is registered. The Specialist Register therefore unfortunately fails to achieve the aim of protecting the public from surgeons who are practising in an area other than that for which they were trained.

*22 April 1999]**[Continued]***SELF-REFERRAL**

The British Association of Plastic Surgeons supports the principle that specialists should accept referrals only from general practitioners (or other specialists). We believe a referral by a general practitioner who is aware of the patient's circumstances and previous medical history is the gold standard. There are however certain problems with this in that some general practitioners may be unsympathetic to requests for private aesthetic or cosmetic surgery. Also there is a perceived lack of confidentiality associated with health centres or doctors' surgeries. Not infrequently a patient will state, "I don't mind my doctor knowing, it's the receptionist who files the letter who is the problem". It may be seen therefore that self-referral, however undesirable must be regarded as a fact of life. It is important that patients who choose this route should be able to ascertain that their surgeon has adequate training and experience in the field and that they should be protected from those practitioners who do not. At present the general public has no way of ascertaining the level of training or experience of surgeons who do not hold NHS appointments. Some surgeons who practise in the commercial cosmetic surgery sector are well trained, suitably qualified and highly experienced. Others, regrettably, are not. I personally am aware of one surgeon who progressed no further than a Senior House Officer grade in plastic surgery before entering this sector. Many members of the Association are aware of similar instances.

ADVERTISING

Some commercial clinics include in their advertisements wording such as "all our surgeons are Fellows of the Royal College of Surgeons". While no doubt this is true and in no way contravenes the requirements of the advertising standards authority the general public believes that this indicates that the surgeons concerned are adequately qualified and experienced. Unfortunately this is not necessarily the case as the old Part II Fellowship is a basic surgical qualification. It is only the Specialty Fellowship and Certificate of Completion of Specialist Training that indicate adequate qualification and experience.

LAY COUNSELLORS

In some (if not many) commercial clinics the initial consultation regarding a cosmetic or aesthetic procedure may be with a lay counsellor. Their role may be just as much to encourage business as to ensure that a patient has a procedure which for them is most appropriate. A patient may be seen by the surgeon only shortly before the procedure is to be performed. The pre-planned procedure is then carried out with not always satisfactory results. An illustrative case history may be helpful.

A patient was referred by her general practitioner to one of my colleagues, requesting liposuction. She was advised that she was overweight and that the procedure was inappropriate. She was advised to diet and informed that the question of liposuction could be considered after she had lost weight. She then referred herself to a commercial clinic where she was seen by a lay counsellor who advised her that a great improvement could be made in her appearance and that the risk of complications or an unsatisfactory outcome was extremely low. She paid a substantial deposit. Shortly afterwards the company in question was the subject of some unsatisfactory publicity on television and she changed her mind and asked that her deposit be refunded. She was advised by the counsellor that the television programme had been the result of biased reporting and that there was nothing to worry about. She decided to proceed and the operation was performed by a general practitioner whom she met only shortly before the procedure. The result was unsatisfactory, the company accepted responsibility and agreed that a corrective procedure would be carried out by a more experienced surgeon who was a Fellow of the Royal College of Surgeons, however he had no significant training in plastic surgery. A further procedure was carried out and the result was again unsatisfactory. I was subsequently asked to examine her on behalf of the defence organisation of the two practitioners concerned. I advised them that the case was indefensible but that they should seek a substantial contribution to the damages from the company because of the role of the lay counsellor.

I believe that this illustrative case highlights the problems involved. Many members of my Association can recount similar instances.

Steps should be taken to protect patients seeking aesthetic or cosmetic surgery who may well be vulnerable. They should be able easily to ascertain that their surgeon has adequate training, qualification and experience in the field of surgery concerned. Initial consultations should only be with a surgeon whose responsibility it is to ensure that patients undergo only those procedures which are appropriate for them and who have no role in furthering the commercial interests of the clinic.

22 April 1999]

[Continued

Examination of Witnesses

MR BARRY JONES, President, British Association of Aesthetic Plastic Surgeons, and MR ALAN LEONARD, President, British Association of Plastic Surgeons, examined.

Chairman

630. May I welcome our two new witnesses. We are very grateful that you have been prepared to come along today and also for your written evidence. Would you be good enough briefly each to introduce yourself to the Committee and say a little bit about your own background?

(*Mr Jones*) My name is Barry Jones. I am a consultant plastic surgeon and President of the British Association of Aesthetic Plastic Surgeons.

(*Mr Leonard*) My name is Alan Leonard. I am also a consultant plastic surgeon and I am President of the British Association of Plastic Surgeons.

631. Could I begin by in a sense picking up on some of the discussion we had in the previous session, which I think you were both present for, so you know broadly the areas that we touched on. I am interested, Mr Jones, in the written evidence that you kindly gave to the Committee. Your organisation talks about "The majority of their patients are frequently gained through seductive advertising rather than by recommendation or direct referral from other doctors." Would you like to say a bit more about your point about seductive advertising in the context of the discussions that we were having in the previous session?

(*Mr Jones*) I am clearly not an expert on advertising, as one of the previous witnesses was, but it seems to me that the purpose of medical advertising should be to provide information and that is all. I cannot see how having a photograph of an attractive breast, nose, bottom or any other anatomical feature provides information and, therefore, I would have thought it would be reasonable if advertising for medical purposes, whatever the specialty, were limited to text and did not include any pictorial elements. I must say I would also agree with the comments that were made about the need or the desirability of having a caveat associated with the advertisement and the caveat which was suggested along the lines of "Any medical treatment or surgery carries an element of risk" seems to be clearly truthful and sufficiently bland as not to offend anybody and yet may, as was pointed out, just make an individual stop and think, even if only briefly, before pursuing it.

632. Would you like to comment also, Mr Leonard?

(*Mr Leonard*) I would agree with what Mr Jones has said. One other point that Mrs Alderson made that I would like to pick up on, I think in response to Mrs Wise's question, is that she said the public are not naive about surgery. I would beg to differ. I think many people seeing an attractive figure in an advertisement will be naive about it and think, I too could be like this. So I would just like to disagree with that point that was made previously.

633. This is a very difficult area because we recognise that we picked up on the advertising issue, the way in which people are enticed into feeling dissatisfied about their own/personal appearance,

but one wonders how in a free society one can actually make sure that people are properly informed if we have a market in health that actually is geared to inducing people to have surgical intervention in respect of their appearance?

(*Mr Leonard*) This is an area of great concern, I am sure, to both of our Associations. We feel that the proper course of action is that people who wish to have surgical procedures should have a consultation with the surgeon who is going to perform that procedure and that one of the aims of that consultation should be to determine that the procedure is, in fact, appropriate and the best thing for them, whereas these advertisements are encouraging people to have procedures regardless of whether they are the best thing for that individual or not.

634. Could I come back to you with the point that I raised with Mrs Alderson in the first session, that you may well have a medically qualified consultant in this private clinic who will see the individual concerned. It will not be a sales consultant; it may well be somebody who is medically qualified and presumably knows the pros and cons of any intervention, but is there not an in-built incentive, if that is a private clinic and the consultant earns his fee as a result of intervention, to go ahead with that intervention, even though that intervention may not in any way achieve the results the woman or man concerned believes, arising from what they had read or listened to, would be the case?

(*Mr Leonard*) That raises the whole question of the ethical standards under which people operate their practices, and if they operated their practices to an appropriate ethical standard, they would not recommend an inappropriate procedure, even though to do so might be to their financial advantage.

635. Would you not accept that if one looks at health systems that are predominantly market driven, such as the American system, we see a far greater use of surgical intervention than we see within the NHS in this country which is a state system? Is not the reason for that because there is an in built incentive for the surgeon concerned to actually intervene rather than not to intervene because the rewards that they receive are based on intervention rather than non-intervention?

(*Mr Leonard*) I do not feel that I can really comment on the American system, not having worked in it. I think I would come back to the whole question which is very topical at the moment of the evidence base for procedures. If the evidence is that a procedure is going to be beneficial then it can be safely recommended, whereas if it is not then it should not be recommended.

(*Mr Jones*) The question that you ask broadens the question enormously.

636. I appreciate that.

(*Mr Jones*) Because no advertisement can achieve the end which is desired. The advertisement must not be misleading or enticing but the issues of which you

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued]

[Chairman Cont]

speakers are related to medical ethics and informed consent. As I am sure you know, if a patient has not been informed of the risks of any given procedure which may occur more than one per cent of the time and goes ahead with an operation, whether it be in the health service or in the private sector, they have not given informed consent. If they have not then by definition that treatment is negligent. I accept what you say about a market driven system, such as in the USA, but I do not think it is true of responsible doctors. You may say "how do you ensure that all doctors are responsible" and I do not know the answer to that question but there is a move at the moment, is there not, within the health service at least to create what one might call an algorithm for clinical care whereby if you have the National Institute for Clinical Excellence which basically sets standards you try to police those standards locally through clinical audit, through the trusts and clinical governance, and then you have the CHI who police the local policing, if you like. That seems to me to be the way that it works. I do not see why one should not have a similar sort of system within the private sector. Whether we are talking about aesthetic surgery or whether we are talking about hernia repair or open heart surgery it does not really matter, the principles are the same. On the issue of clinical governance, which seems to me to be very important here, one of its most important and most revolutionary ideas, if you like, is that the chief executive within an NHS trust and the board of that trust take responsibility for ensuring that clinical governance is proceeded with properly, ie that standards of clinical care are proper. Within the private sector at the moment reputable hospitals, if I can call them that, will have a similar type of system with a medical advisory committee, it may have a different name but it performs a similar function, but some clinics will not accept responsibility for what goes on. So that, for instance, if there is a medical legal issue arising out of a problem which has occurred with surgery there the clinic will say "this is not our problem, it is the doctor's problem". Sure, it is the doctor's problem in part but the clinic surely must be made to accept some responsibility for what goes on within that clinic by vetting the qualifications of the people who work there and ensuring that they are qualified to do what they are doing and ensuring that when they are doing it the standards to which they are doing it are acceptable.

637. So you see some marked distinctions between quality safeguards currently operating depending on the organisations?

(Mr Jones) I think there is a huge difference, an enormous difference, yes.

(Mr Leonard) I would like to come back on your previous point because we made an enormous leap from the seductive advertisement to the possibility that the doctor might be influenced by financial matters.

638. Can I say why I made that leap. It was my fault. I made that leap on the basis of the ASA response in the previous session which was rather than looking at the powers currently, the ASA is looking at how we ensure that in the clinic the patient sees someone who is properly qualified and responsible. That is why I felt that the leap had to be

made because I am not sure that that offers anything a great deal better than is currently the situation that we have. I am not convinced that within the environment of a market driven system the patient is protected in the way that has been implied.

(Mr Leonard) That may or may not be the case but, with respect, I want to draw attention to the steps which we leapt over which are that in many organisations the point of first contact will not be with the doctor or surgeon but they will be with a lay counsellor who may or may not hold some other qualification and it may well be very definitely to their financial advantage to bring business to that clinic. Only on Friday a patient consulted me about a cosmetic procedure and she came to me because she had been to a clinic and had been dissatisfied with what she had been told by the lay counsellor. She went enquiring about one specific operation and she came away having been advised that she should have another minor procedure added to that and another very major procedure added to it. She was advised that it would make economically good sense to do so. She asked about complications and that part of the conversation was discouraged. All of this took place with someone whose qualifications she did not know and could not ascertain. I think that similar stories will be repeated by colleagues and members of my Association all over the country.

639. Before I bring in some of my colleagues, could you briefly show how within your organisations you regulate the provision? What quality safeguards are there within your Associations in terms of the work of your members?

(Mr Jones) At the beginning in order to become a member of the Association—Alan can speak for BAPS—one has to be a consultant within the NHS or have been one. So, therefore, any member will have been through the peer review of the interviewing system, etc., within the NHS and also you would have to have the CCST which is the certificate of accreditation, if you like, in that you have trained in plastic surgery in the way that is laid down by the Royal Colleges of Surgeons. I guess the first regulation is in order to become a member of the Association. We do issue guidelines to our members as to, in a sense, how they should practise. We do not encourage practice within clinics which advertise in the way that we have spoken of.

640. When you say that you do not encourage it, how do you prevent it? What is the mechanism whereby you would be able to stop it or advise against it?

(Mr Jones) That is a very good question and a topical one as it happens. The answer is that it is difficult but it is something that we are acutely aware of. We can respond only to information which we receive, if you like, and we have had such an incidence recently which was discussed at Council of a group of private hospitals promoting themselves in a way and dealing with self-referrals in a way which we did not feel was proper and members of our Association are working in that group of hospitals. I have written to the chief executive of the group which owns the group of hospitals to request a meeting with her in order to discuss it with them initially. Of

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued]

[Chairman Cont]

course, the ultimate sanction we have would be to disbar a member from being a member, which we have done in the past.

641. What difference would that make to that member in the situation in their work?

(Mr Jones) You mean would they be able to continue to do so?

642. Yes, they could continue to work?

(Mr Jones) Yes, they could.

643. So it is not really a sanction in a sense from their point of view?

(Mr Jones) It is a sanction but we would not have that sanction because our's is only a professional association. There may be many competent plastic surgeons fully trained, accredited, NHS consultant type plastic surgeons who choose for their own reasons not to be a member of our Association and, of course, that is their choice. The role that you are speaking of is the GMC's role in the end.

(Mr Leonard) In my written evidence I have given details of the syllabus and training and examination leading to the Certificate of Completion of Specialist Training which in turn enables a surgeon to be listed on the specialist register of the GMC as a plastic surgeon. In terms of sanctions, exactly the same things apply. Some years ago my Association did remove from membership a couple of people who we felt had stepped out of line on the question of advertising. We have not done so recently, because with the relaxation that the GMC have allowed on the question of advertising, our legal advice has been that it would be difficult for us to do so. But I fully accept your point. It is not actually a sanction in that they continue to practise in exactly the same way.

Dr Brand

644. It is very interesting because you have a model in your submissions, and which you have just said this morning, very much of a surgical medical model, whereas the rest of the world seems to have moved more towards teamwork. Is that because you feel that you have no control over the team you have to work with, and, if I go back to the issue that the Chairman was raising with you, how you get your referrals and who makes the initial assessment and who does the initial negotiation with the patient?

(Mr Jones) I am not sure I understand your question entirely but I will answer it as best I can.

645. I think there are two models, are there not? One is that you are entirely in charge as a consultant surgeon?

(Mr Jones) You mean a model of care?

646. And you are the controller of the care, not only the standards but also whether it should be carried out, and presumably that is the sort of model you see in a private general hospital when you operate there? There is a different model where one of your members may be working in a specialist cosmetic surgery clinic, where most of the negotiation, early contact, advertising, would be done by the clinic and you come in to carry out the work?

(Mr Jones) We would hope that none of our members is working in a situation like that.

647. The majority of cosmetic work is done in those sorts of circumstances?

(Mr Jones) That may be so. Numerically, I could not either confirm or deny that fact. It may be so but that is not the way that we think it should be done.

(Mr Leonard) I would like to personalise that. I do not work in such an environment but if I were to I would feel that it was essential that I would see the patients long enough before the operation for them to be able to change their minds if they so wished, that, regardless of what had taken place previously in terms of counselling and advice that this was a good procedure for them to have, I would want to feel that I could take them through the procedure, its possible benefits and its possible risks, in the proper way of taking them through the question of informed consent and that they should free at that stage to change their mind and say, "Actually, that is different from what I have been told already. Thank you very much but I will not have this operation." I think that if patients are gained by advertising and self-referral and counselling by people who may have a financial interest in their having a particular operation, I would not feel comfortable working in that environment. I think therein lies the dilemma in that clearly there are people who do feel comfortable working in that environment but I feel that it poses difficulties in terms of informed consent.

Chairman: Could I bring in Audrey Wise on this point.

Audrey Wise

648. Going back to Mr Leonard's description of what his approach would be, if he were working in such a milieu he would probably find that the patient had already paid for the operation. Does your Association have a view about the fact that patients, or potential patients, are often required to pay even before they see the doctor? What advice do you give your members about it?

(Mr Leonard) I have to say that that particular question has not come before the Council of my Association and we have not, therefore, given our members advice about it. I do refer in my written evidence to another patient who was required to pay in advance and who asked for her payment to be refunded. She did subsequently, in fact, change her mind but I think if people are going to pay in advance, it clearly would be important that they should be able to, just as, if you like, referring again to the financial services industry, maybe there should be a cooling-off period in which they can have their money refunded.

649. Has your Association come across this point, Mr Jones?

(Mr Jones) Not specifically, and I come back to the same point that I made before, that we would hope that our members are not working in that sort of situation and so it has not arisen as a specific question for Council to consider, but it all comes back to good medical practice and informed consent, and the reason that Mr Leonard wants to be sure that his patient has given proper informed consent, whilst I am sure for the most part altruistic, is not entirely so because he is negligent if he does not do that. That is not at issue.

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued]

Mr Gunnell

650. I am wondering about the titles that people give themselves. There is no restriction on the use of titles such as "adviser" or "specialist adviser", which can be very misleading because it can mean anything. If you saw a clinic which was advertising that you would be seen by either an adviser or a specialist adviser, would that not immediately alert you to the fact that that clinic possibly was not being completely honest in the person that they were saying would be available?

(*Mr Leonard*) I do not have a problem with the term "adviser" because my perspective is that an adviser can be anything. I do have a difficulty about the term "consultant" because I believe that the general public equate that with an NHS-type consultant, whereas in law that carries no weight; anybody can call themselves a consultant. My Association has recently explored that point and found that, in fact, there is nothing we can do about that, that anybody can call themselves a consultant. So I have more difficulty with the use of that term, which, as I say, the public generally perceive as being the same thing as an NHS consultant.

(*Mr Jones*) In a sense it is a problem between the confusion of what is in law a courtesy title and what is generally perceived in this context as a rank, if you like.

651. Yes, but it is important, is it not, that before anyone has medical treatment they are seen by a person with appropriate medical qualifications?

(*Mr Jones*) This comes back to informed consent again. The only person who is in a position to gain informed consent from the patient is, in the case of surgery, the surgeon who is going to do the operation. Moreover, as I am sure the Committee will be aware, the consent form which the patient signs is not evidence of informed consent. Evidence of informed consent is the discussion which has taken place between the doctor who is going to do the procedure and the patient and that that be recorded in the notes. The fact that a consent form has been signed in law means nothing.

652. Would you not need also to be absolutely sure that if a person is getting laser treatment, for instance, as part of cosmetic surgery, the apparatus has been regulated and is up to standard and that the person who is giving it is actually trained in the use of that apparatus?

(*Mr Jones*) Yes, and again I refer back to comments that I made previously. As far as the competence of the individual is concerned, that comes back to the medical advisory committee of the hospital or whatever title that has, who must vet that the person has been properly trained. In the example of the particular private hospital in which I work, anybody who wants to use the laser for treatment, whether he be a plastic surgeon or a gynaecologist or whatever else, must produce evidence that he has been trained in the use not only of lasers in general but of that particular laser, and, as far as I understand it, it is the responsibility of the local health authority to ensure that the laser is being used in the proper surroundings and that the proper precautions are being taken and that the machine itself is being properly maintained.

653. And that there is appropriate protective apparatus—glasses and so on—for both the patient and for the operator?

(*Mr Jones*) Absolutely, and other staff.

(*Mr Leonard*) Chairman, on that specific point of laser treatment, I have here a copy of a draft document on guidelines for cutaneous laser therapy, which is at present under discussion by the British Medical Laser Association. As it is just in draft form I think I should seek their permission to forward it but I am sure it will very shortly be finalised and I would be very happy to forward it to you.

Chairman: That is very helpful, thank you.

Mr Gunnell

654. I think that has explored the issue. You still leave me with the feeling that where it can simply advertise that it has an adviser, and this is as you say a much more open term and does not actually imply anything at all—

(*Mr Leonard*) No.

655. So the person has no right to expect that they will get qualified medical advice from a person who is described in that way. I would have thought that you are able to see clinics which are likely to cut corners by the fact that they use these terms in their advertisements.

(*Mr Jones*) Yes.

(*Mr Leonard*) May I continue on this question of advertising to highlight a point that I made in my written evidence. That is the question of advertisements that say something like "all of our surgeons are Fellows of the Royal Colleges of Surgeons", which in the terms of the Advertising Standards Authority is doubtless true and does not pose a problem but, again, it is a question of the public perception and the public may well perceive that means that they are fully trained in every way to perform surgery of this type whereas the reality is that fellowship is a basic surgical qualification and training in surgery of this type only follows after that qualification has been achieved.

Chairman

656. You have taken me on to the question that I wanted to ask you in some detail and I am grateful for those comments. In your organisation's evidence, Mr Leonard, you say that unfortunately if a member of the public makes an enquiry of the GMC they will be told only if a particular surgeon is on the Specialist Register, they will not be told in which speciality the surgeon is registered and the Specialist Register, therefore, fails to achieve the aim of protecting the public from surgeons who are practising in an area other than that for which they are trained. I would be interested in you expanding on that. Can I press you both a bit further on the issue of whether there ought to be a review of the level of qualifications and skills for cosmetic surgeons and, if so, who perhaps would undertake the review? Are there any minor procedures that should be perhaps outside such a review?

(*Mr Leonard*) First of all, on the question of the Specialist Register, I only discovered that recently, that the enquirer would be told "yes, they are on the

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued]

[Chairman Cont]

Specialist Register" but not on which register. I cannot comment further on that. On the question of the regulation of assessment of skills of people practising in this sector, I think that ought to be done. In my evidence I have mentioned one case of which I have personal knowledge where the person concerned had minimal training in this field. Equally well I have mentioned that there are many very highly trained, qualified and experienced practitioners. I feel strongly that there should be an overview and I would suggest that just as I have detailed the training and examination that is supervised by the Royal Colleges, that the Royal Colleges would be the appropriate bodies to do this.

(Mr Jones) I can only really endorse what Mr Leonard says, that if it is the responsibility of anybody it is that of the Royal Colleges. I think that a review of competence and training would be welcomed.

657. Are there any minor procedures that might not be included in that review? Do you feel that there are some that do not need to be included or would you include the whole lot?

(Mr Jones) I suppose it would depend upon where you drew your line of aesthetic surgery, which is very difficult in fact.

Audrey Wise

658. There has been a brief mention of lasers. The regulation of certain categories of lasers is through the Registered Homes Act. Do you consider that is the right way? Do you consider that it is working properly? Are you satisfied with it?

(Mr Jones) The fact that the regulation of medical consulting rooms comes under the Registered Homes Act seems to me to be slightly incongruous. I have had some correspondence about it in the past. From a personal point of view I have a consulting room in which certainly I do not use a laser, but did until recently carry out minor surgical procedures, removing moles and that sort of thing under pure local anaesthesia with no sedation or under intravenous drugs. I have had some correspondence with the local health authority about this because its regulation, as you know, is by the Registered Homes Act. I suspect that it would perhaps be better if there was a body which was more specific because the Registered Homes Act has such a broad remit that this seems to be something that somebody tacked on the end without really planning it in the first instance. I am not sure that they are the best group to do it. My correspondence with them was about anaesthesia because they said any minor operating rooms, so to speak, must be registered which carry out procedures under anaesthesia. Those were their words, "under anaesthesia". My understanding of "under anaesthesia" was general anaesthesia, as it was of the Royal College of Anaesthetists, but the body that we are speaking about define "under anaesthesia" as local anaesthesia. It may be a matter of semantics and I only pursued it because I was being awkward, in a sense, or curious.

Chairman

659. Was that a local definition? Was that something that was simply within the health authority where you were based or was that something where they were working on national guidance in that respect?

(Mr Jones) My correspondence was with the Chelsea, Kensington and Westminster Health Authority and in the end their bottom line was "this is what we say it means and therefore that is what it means". I suggested that they should perhaps correspond with the Royal College of Anaesthetists who I would have thought would have been the experts but they did not wish to do that.

Audrey Wise

660. Of course, an epidural is a local anaesthetic.

(Mr Jones) An epidural, with respect, is a regional anaesthetic.

661. There are three categories in other words?

(Mr Jones) Yes.

662. But your correspondence only enters into the two?

(Mr Jones) It is not really relevant to this discussion.

663. Getting back more specifically to this discussion, the Committee had an informal briefing yesterday from Professor Blackwell who is highly qualified in this field and himself is an inspector and he described to us the huge number of faults, inadequacies, sometimes very major, that he discovers in this field every year when he makes his inspections. Also we discussed with him the self-referral aspect and the approach of some doctors who have actually give blanket permission to the clinic to regard anybody who comes as having been referred by them. That sounded to me like professional misconduct but it does not seem to have been pursued in that way. How would you regard such an approach by a doctor?

(Mr Jones) We are not speaking about lasers now I presume?

664. It was in connection with lasers.

(Mr Jones) But it could apply to anything?

665. Yes, it could. It actually arose in the context of lasers. There seems to be an opinion in some circles that it is minor or trivial or safe whereas actually none of those adjectives could properly be applied to laser treatment.

(Mr Jones) No, I could not agree with you more. I think to some extent it comes to the ethics of the institution in which the laser is being used and the effectiveness of the policing procedure. In the private hospital where I work I know that the use of the laser is policed very closely. When we wanted to import, as it were, a laser for a day for a teaching purpose we had quite a testing procedure to go through in order to be allowed to use it even for the day by someone trained to use it. The issue of self-referral is a broader one. I cannot imagine that any doctor in this country would argue with the fact that in an ideal world one would prefer referrals to come from general practitioners or other specialists. Nevertheless, one has to live in the real world and there are many

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued]

[Audrey Wise Cont]

reasons why, in the field of aesthetic cosmetic surgery, patients will not want to seek referral from their general practitioners. It may be because the general practitioner is not interested and I do still hear not infrequently that that may be the case. And to be fair to a general practitioner, he has an impossible job and he cannot know everything about everything. Again a frequent comment is that the general practitioner is either a personal friend—to which my response is, “Then you should get another general practitioner”—or, more frequently, “I live in a small community and I am concerned that letters will be opened by the practice staff and not by the general practitioner, who may not be bound by the same issues of confidentiality that he would be.” Thirdly, this is perhaps the only true market in medicine in a sense and patients, at least patients who are informed or manage to get themselves informed, will often seek out surgeons who have a particular expertise or reputation in a particular field. Many of those will still go through their general practitioner but by no means all will. So a brief answer to your question is that I and my Association would say unequivocally that referral through another doctor, be he a GP or medical specialist, is the ideal route, but I think one has to accept, in this field particularly and in others, I am sure, that self-referral will occur and it is then the responsibility of the specialist to inform the general practitioner, unless the patient specifically requests him not to, and that becomes a very difficult area.

Audrey Wise: But does this not then impose an implied requirement for the surgeon concerned to operate himself under the highest ethical standards since there is a preliminary stage being missed and so he is not in a way having the advice of the person's GP? Do you think that there should be some particular regulation, ethical regulation, because ethics should be self-imposed but it does arise that they are not and so there is a concept of misconduct? Should there be higher standards required even in this field than in general because the surgeon is acting in this less than satisfactory way perforce, and so you do not want to take away from the patient any rights but then should not this be recognised in the professional regulation?

Chairman

666. Could I add a rider to Audrey's question. Going back to your point about why people will not use GPs, and, of course, I understand fully and appreciate the point you are making, but looking at the issue I raised with you earlier about the interest, the financial interest, that the doctor may have in ensuring that the patient does go through treatment, what about the issue of some independent person that they see before they enter into this process? Would that not be in the interests of the patient and also in the interests of ensuring that the quality of care was appropriate? I go and see an independent person who says, “You look perfectly all right with a bent nose and two cauliflower ears. You will not be improved by some plastic surgery.” That might be objective and helpful to me in those circumstances but it would not be the response I would get from the

doctor fronted up in the way the ASA suggested in a clinic where that doctor may well be the person who treats me?

(Mr Jones) I will leave this to Alan to deal with but one brief comment at the beginning just to make a distinction in the way that doctors are paid, which is important in the point that you are making. If a patient comes to see an independent practitioner within the private sector, whatever kind of surgery he is doing, there is a contract between the patient and the doctor and you may say the doctor is greedy and, therefore, will do an operation which is not necessary. He would be foolish and unethical to do so but he may. On the other hand, you have the other circumstance that you have mentioned, where you have a doctor who is employed by a clinic on a sessional basis, perhaps for a half a day, and he sees the patients half an hour or 20 minutes before the operation is to be done. If he follows Alan's guidelines and he is expected to do, shall we say, five operations in that half-day and he thinks four of them are not suitable and he sends them away again, the clinic who is paying him I imagine will not be wonderfully impressed. So he in a sense is under a different pressure, which is, I would have thought, perhaps more intense because the independent doctor seeing a patient with whom he has a financial contract does have his own conscience and ethical considerations to sleep with, so to speak. But my other point is, who could give the third-party advice that you are asking for other than a plastic surgeon and one must accept that medicine by its nature is always a matter of opinion; it is rarely a matter of fact. So if you put ten plastic surgeons together, you may get ten different opinions. It does not mean that necessarily it may be one is right and one is wrong but it may not.

667. Having looked at some of the advertisements that Mr Mohammed has shown, certainly to me and other Members of the Committee may have seen them, I believe there is a process whereby women in particular are induced into going for operations, particularly on breasts or other parts of their body, when really somebody ought to be saying, “Look, do you really need to go through this?” and the current lack of any form of check, independent check, leads to people paying substantial amounts of money out for operations that often leave them feeling perhaps worse, which is the evidence that we have picked up? What I am saying—and I am floating an idea that may well be thrown out and rejected—is, would it not be appropriate in everyone's interest to have that independent check somewhere built into the system, that a patient sees independent opinion very early on, possibly funded within the remit of an umbrella organisation and independent sector, and that is a check from everyone's point of view? That person is objective. There is no connection in any way with receiving money from that patient. The patient would not have paid for that advice; it would be independent?

(Mr Jones) With respect, it may on the surface appear to be a good idea. I do not see it as being very practical and I think one has to accept that there are other incentives for doing procedures which may not be entirely right other than money, and within the

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued

[Chairman Cont]

NHS the same thing can happen if the doctor has an idea that this particular method of treatment is good and he wants to present a paper to the Society.

668. I accept that point entirely. I am well aware of it.

(Mr Jones) So my answer would be, if you were to do such a thing in this field you would probably need to cover all fields of medicine with it and I just do not see how practically you could do it, but I do think you can reduce a lot of the inducement aspect of it by control of the type of advertising which is allowed and the elimination of the lay adviser, counsellor (call them what you will) who sees the patient in the first instance.

(Mr Leonard) May I come in on that point as well because in my written evidence I gave a little case history which illustrates precisely this point, that the patient will not necessarily accept the advice of such an adviser, because in that I recounted the patient who went to one of my colleagues, who was clearly operating to the highest ethical standards, with which I have no difficulty, and he advised her that the operation she wanted was inappropriate and should not be performed and she should go away and go on a diet. She then went to a clinic, had the operation performed, had an unsatisfactory result and subsequently sued. I do not think you can say that an independent adviser like that will cure these problems.

Audrey Wise: It might not.

Chairman

669. I accept your point. I understand the point. It just strikes me that we need to look at the checks that are not there at the present time, and I fully understand the point you have just made.

(Mr Leonard) I would also like to take you up on the point that you made that this independent person would say, "You look perfectly all right the way you are," but a great deal of time is spent in consultation with these people exploring the reasons why their perception is that their appearance is unsatisfactory, and what one person's perception is, another person's perception may be entirely different. I think that is precisely one of the areas that requires specialist training and experience. It is the whole question of the consultation. Training in surgery is not just about surgical operations; it covers many other aspects as well.

670. Would you concur, on that point, with the argument that Mr Mohammed put forward, that we should not have pictures of apparent perfection that people compare their bodies to?

(Mr Leonard) I would concur absolutely with that. May I just briefly also come back to your point about the lasers and refer you to *Guidance on the Safe Use of Lasers in Medical and Dental Practice*, the Medical Devices Agency 1995. This document on cutaneous laser therapy guidelines, which I will forward to you, talks about laser protection advisers, local laser safety rules and so on and so forth. It is all dealt with in this document.

Audrey Wise

671. One of the things which has been explained to us is that there are some people who think that there is already over-regulation in the use of lasers and there is quite a lot of pressure for at any rate certain categories to be deregulated. How would you view that? Mr Jones, you did indicate that you thought there should be different regulation but I did not pick up that you thought there should be less.

(Mr Jones) No.

672. But through a different vehicle from the Registered Homes Act. How would you feel about any moves to deregulate any categories? What do you think should happen when an inspector finds this huge level of error and inappropriateness in the handling of lasers?

(Mr Leonard) I can only say what happens in my own hospital. When I wanted to introduce a new type of laser, which happened to be quite low power and carrying relatively little hazard, the hoops I had to jump through to get this introduced were quite difficult. It was made abundantly clear to me by the laser protection adviser that if they were not all complied with I could not use it.

673. Are you happy with that?

(Mr Leonard) I am quite happy with that.

(Mr Jones) I can only support that. May I come back very briefly on your earlier point about "I think you look perfectly all right the way you are".

Chairman

674. It is very nice of you to say so.

(Mr Jones) I was not looking anywhere in particular. It is a very important issue. There is good published evidence, mainly from Plymouth, of the positive benefits that aesthetic surgery does have on people's self-perceptions, not always I fully admit but often. As Mr Leonard said, it is very important that the surgeon concerned explores with the patient the reason for their dissatisfaction. You or anybody else may say "you look fine to me" and in fact it is very often the case that when women come seeking advice about facial appearance, which is my particular interest, their husbands will almost invariably say "I think you look fine", which is very reassuring to the woman.

675. But he is paying.

(Mr Jones) He still has to pay even though he thinks she may look fine in the first place.

Mr Walter

676. We are dealing in this section of the inquiry essentially with minor surgical procedures and particularly cosmetic surgical procedures, sometimes not only minor. I saw the way you reacted to that. What I want to explore is if I am an informed member of the general public, as some of my constituents think I should be, or if I am the Advertising Standards Authority, there does seem to be a professional minefield here of different organisations. You two represent the British Association of Aesthetic Plastic Surgeons and the British Association of Plastic Surgeons. There is the

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued]

[Mr Walter Cont]

British Association of Cosmetic Surgeons, there is the European Academy of Cosmetic Surgery. We have had a note this morning, and my colleagues have given me this one because they think I will be able to pronounce it, from the British Association of Otorhinolaryngologists, head and neck surgeons to everybody else. They point out that if you had a job done on your nose or your ears then they might be the people who would carry it out. Then there are the maxillofacial surgeons, the max fax people, ophthalmic surgeons doing jobs around the eyes. The ASA themselves in their evidence to us said "Because of the number of professional associations that exist to represent cosmetic surgeons...it has proved difficult for us to obtain a consistent view with which to inform our advertising policy." It does appear to me that you have this proliferation of organisations that are involved in this area of surgery and there is nothing between that and the Royal College of Surgeons, and in fact I am not even sure that some of these people are members of the Royal College of Surgeons but you might be able to enlighten us on that. We have had evidence also that if you ask the GMC "is Mr Joe Bloggs on your register as a specialist in a particular area", all you are told is "yes, he is a specialist" but you are not told which specialism. Do you see some need for an overarching body that could represent the industry? I hesitate to use the word the industry but I think you probably know what I mean.

(Mr Jones) I do, yes. I think it is a very good point and again a current one. The Council of our Association and the BAPS have had meetings in the very recent past with representatives from the otorhinolaryngologist and the ophthalmologists and the maxillofacial surgeons discussing exactly this issue. I could not agree with you more that for a lay member of the public it is a difficult or perhaps impossible task to figure out which is what amongst them. Our concern comes down again to training at the beginning. If one starts at the beginning our concern is as to the training of the surgeons. As I mentioned in my written evidence, there are certainly ophthalmologists who have specific training in aesthetic surgery of the eyelids and there are certainly ENT surgeons who have specific training in aesthetic surgery of the nose. The only recognised training programme in cosmetic or aesthetic surgery generally recognised by the Advisory Committees of the Royal Colleges of Surgeons is the CCST in plastic surgery. Maybe that is something which needs to be addressed but I think I would be right in saying that as things stand.

(Mr Leonard) Yes, that is right.

(Mr Jones) Our view again would be that an ENT surgeon or an otorhinolaryngologist who is specifically trained in aesthetic surgery of the nose is presumably going to do a good job in that field. Whether he would have specific training in other areas of aesthetic surgery is another issue. Whilst I could not agree more with the overall tenet of your question, "would it not be easier for the public if there was just one body to which perhaps you had to qualify to be a member" I guess the obvious answer would be yes but the implementation of such a thing is difficult.

677. Perhaps I should not be asking you this question but I have sensed in some of the evidence that there is a degree of professional jealousy between your various Associations. Is that fair?

(Mr Jones) There is professional jealousy amongst professionals. As somebody who has worked extensively in the field of cleft lip and palate surgery, cranial facial surgery, I can tell you that it is exactly the same there, it does not have to do with the aesthetic service specifically. I do not think that is a major problem. I think it is more a question of the fact of how do you construct and define a training programme in a particular field and then ensure, as far as you can, from the public's point of view that the people doing that have followed the training programme? Maybe we need to be broadening the discussion to training in aesthetic surgery in general and how do we assure the public that individuals are properly trained to do it.

(Mr Leonard) There is a fundamental distinction between those who have gone through a training programme, be it in plastic surgery in which they have been trained in all aspects of cosmetic surgery or be it in ENT surgery where they have probably been trained in rhinoplasty, maybe ear surgery and maybe some other aspects of surgery, ophthalmic surgery where they have been trained in surgery of the eyelids, and maxillofacial surgery where again they may have received training in some aspects of cosmetic surgery. The common denominator is that they have all gone through proper training programmes supervised by the specialist advisory committee of their speciality. They have received a Certificate of Completion of Specialist Training and have gone forward to the STA and have their name on the Specialist Register. There is a fundamental difference between that group of surgeons and those other practitioners who have not completed such a training programme. In my written evidence I mentioned the general practitioner carrying out liposuction, the surgeon who then was called in to sort out the problem, who had a fellowship in surgery but had no specific training in the field whatsoever. That is the fundamental difference. That is just one example. There are countless examples. I kept my written evidence to evidence I could stand over in the witness box because I have personal knowledge of that case, but there are many others that my members can attest to. There is that fundamental difference between those who have done a prescribed course of training and got their certificate and are on the specialist register and those who have not and are not.

(Mr Jones) And an important aspect of that training, which maybe is not appreciated as well as it might be—and I have to say I do not have intimate knowledge of the training in ENT or ophthalmology or maxillofacial but certainly in completing the CCST in plastic surgery there is a specific module on ethics and clinical governance and anybody who has a CCST will have been examined in their knowledge of that specific clinical practice, which, given some of our earlier discussion, I think is relevant and important.

678. Is there any way in which the patient would know, could know, which body a surgeon belonged to other than asking him?

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued]

[Mr Walter Cont]

(Mr Jones) They could contact the body concerned and ask them.

679. But as we have already discovered, in a lot of the work we are talking about here the patient is making contact with the clinic or the hospital and they imagine that the hospital would make sure that if they are doing a rebuild job on somebody's ear, the person doing it is qualified to do it but—and this has come up in earlier questions—there is no check on that?

(Mr Jones) At the moment there is not but that is the fundamental problem, I think, which should be addressed, and I say again, as I did earlier, that it seems to me that perhaps the most efficient way to make that happen would be, as with the NHS trusts, to make the hospitals or clinics accept more responsibility or the final responsibility for what goes on underneath their roof.

(Mr Leonard) This is also why I made the point about the specialist register, the public not being able to find out in which specialty the specialist was registered.

Mr Austin

680. It seems to me it is a nonsense that the GMC will not say which speciality people have specialist training in?

(Mr Jones) The reason that they do not, as I understand it, is that many surgical specialties overlap and I think the GMC think that it is difficult to be sure where one begins and another ends. To give you an example from personal experience, in the health service I do craniofacial surgery, which is mainly bony facial surgery, but I am a plastic surgeon. I am not a maxillofacial surgeon but I have training in that aspect of craniomaxillofacial surgery, so do you say that because I am not on the maxillofacial surgery register I cannot do that? I think that is maybe where the problem lies.

681. You have identified an area where there is a grey area and an overlap but in effect there is nothing to stop you practising in some totally unrelated field of surgery?

(Mr Jones) No, none. I could be a heart surgeon if I wanted.

682. And the clinic could still say you were a specialist?

(Mr Jones) The GMC could say I am on the specialist register but, of course, I would not get very far, I do not think.

Dr Brand

683. As a member of the Royal College of Surgeons that tries not to do anything that is unpleasant, is not the question really one of making sure that the skills applied match the job that needs to be done, and surely it is going to be quite difficult to do that entirely through registration? Is not the issue that you have highlighted a number of times now, Mr Jones, of clinical governance and accreditation of surgeons working within either hospitals or clinics, also a very important way of getting this accountability right?

(Mr Jones) Absolutely.

684. If a clinic allows someone who is inexperienced and unqualified to carry out a procedure they should not be doing, they ought to be liable?

(Mr Jones) Yes, I fully agree.

685. I would not like, Mr Chairman, to have a situation where because something is defined as a cosmetic procedure I cannot tie off skin tags or apply a bit of liquid nitrogen, because that is within the scope of most general practitioners and it is not unreasonable?

(Mr Jones) But that is why I answered the question earlier on, would you exclude any particular procedures, in the way that I did because I think it is very difficult to define.

686. Are you doing any work on classification of procedures, because clearly you have clear ideas on what should be registrable? Are you matching that to the sort of work that should be carried out?

(Mr Jones) That then comes within the training programme again, Alan, I think it would be fair to say, would it not?

(Mr Leonard) Yes, that is true. I think the other way of approaching this problem which the Royal Colleges are looking at at the minute is the whole question of re-accreditation, which clearly is an enormous task but is undoubtedly going to happen, and the Colleges are at the minute exploring different possible ways of doing that. I think all that we can say at this stage is that the important thing is whatever arrangements are put in place they should apply equally in the private sector and the National Health Service and equally in the cosmetic surgery sector.

Mr Austin

687. I think it was Mr Jones who actually referred to this whole area of operating in a true market or a real market. Basically we are talking about commercial organisations providing a commercial service, selling a product. What do you see as the role of Trading Standards?

(Mr Jones) We are talking about more than that, though, are we not? We are talking about independent practitioners doing aesthetic surgery and we are talking about commercial organisations of the type that you mentioned and they are in a sense different in the way that they practice. I am not an expert in the law on Trading Standards and it would probably be inappropriate for me to comment on the powers of that particular body. I think the solution to this problem, if there be one, and the regulation to it lies in, as I said, clinical governance, which must involve the hospitals concerned and CPE, or continuing professional education, as Mr Leonard mentioned, so that not only are surgeons who do this work properly trained in the first place, but we ensure that they continue to keep up their knowledge, just as they would need to do in any other field of medical practice.

Chairman: Do any of my colleagues have any further brief points?

22 April 1999]

MR BARRY JONES AND MR ALAN LEONARD

[Continued]

Audrey Wise

688. Yes. There was correspondence between Ann Clwyd, MP, and Baroness Jay about cosmetic surgery, and Baroness Jay's letter finishes up by saying: "Our advice remains that anyone seriously contemplating cosmetic surgery in the private sector should check the credentials of the surgeon through the GMC, or through the British Association of Plastic Surgeons or British Association of Aesthetic Plastic Surgeons." We have explored how far the person would get in checking through the GMC, which is nowhere at all. How far would they get in checking with you? If I said, "I'm contemplating something or other"—liposuction or whatever—what advice would you give? what advice would you give?

(Mr Jones) What advice would our Association give?

689. Yes. It says, "If you are contemplating it, check the credentials of the surgeon through" So I write and I say, "I want to have this and I don't know what's what. It all seems a jungle. Advise me." What advice would I get?

(Mr Jones) If you contact the Association you will, if you request it, receive an information sheet about the particular procedure that you want to know about, in which will be cautions about risks and complications as well as benefits and what is involved. If you write and say, "I want to know the name of somebody who can do it," or words to that effect, then the Association would provide you with a list of its members, but it cannot say, for obvious reasons, that such-and-such is good at this and such-and-such is not. We would assume that with any aesthetic procedure that anybody who was a member of our Association—well, we know that they are properly trained to do it, but it would still be true to say and unarguable that within that Association some will specialise in one area and some will specialise in another.

690. Have you anything to add to that, Mr Leonard?

(Mr Leonard) Not really. If you contacted the British Association of Plastic Surgeons you would be told whether the surgeon about whom you were enquiring was one of our members or not.

691. And if I have just seen an advertisement for this and I think, this sounds wonderful and I think I should do this, how would I know you exist? The advert would not tell me, would it? The Advertising Standards Authority would not make them tell me, so how would I know?

(Mr Jones) Unless you went and asked your general practitioner or you telephoned the Royal College of Surgeons, for instance, I guess that you would not.

692. So in addition to our suggestion that the Advertising Standards Authority in pursuing the concept of social responsibility should make them say "All surgery carries an element of risk", it might be useful if they also say "All potential patients are advised to consult their general practitioner"?

(Mr Jones) Yes, I think that would be very reasonable.

(Mr Leonard) Yes, absolutely.

Dr Brand: Can we make absolutely sure then, Chairman, that the general practitioner has some advice as well. I rely on ringing a friendly local NHS plastic surgeon for further advice on that.

Audrey Wise

693. Can you suggest any more satisfactory way? Do you think that the advice that was given by Baroness Jay is adequate? She also says: "The statutory control of the private sector is provided through a system of registration and inspection which is wholly delegated to health authorities under the Registered Homes Act 1984." You have said that you do not think that the Registered Homes Act is really the best vehicle. Is that the opinion of both of you?

(Mr Leonard) It surely is only dealing with the environment in which the treatment is carried out.

Audrey Wise: The term used in this letter is "the statutory control", which is a very broad term. Thank you.

Chairman

694. Do any of my colleagues have any points? Do either of the witnesses have any points that they would wish to add to anything that has been said so far?

(Mr Jones) Other than to thank you for inviting us, no.

Chairman: Thank you, it has been very helpful. You have promised to follow up with one or two additional items and we look forward to having them. Thank you for your help.

Memorandum by Transform Medical Group**INTRODUCTION TO COSMETIC SURGERY (PM 26)**

Cosmetic surgery is largely performed to correct or reduce perceived defects, to enhance or enlarge various features of the body or to minimise the effects of ageing.

Traditionally, cosmetic surgery has been the preserve of the affluent older woman, but more recently there have been signs that almost all sections of the population are prepared to accept that there are benefits to be gained through cosmetic surgery. Increasing media exposure plus improved techniques and technology have fuelled demand for breast enlargement and fat removal, particularly from women in the 21 to 40 age group.

*22 April 1999]**[Continued*

There has also been a substantial increase in interest from men of all age groups. Cosmetic surgery is predominately carried out in the private sector, but can be obtained on the NHS on a strictly regulated basis, if there is evident psychological or functional need.

Demand for cosmetic surgery is likely to grow rapidly to a level of over £200 million per annum by the year 2002 (source: Keynote report 1997).

There would appear to be little evidence of poor practice in the private sector (ref. Baroness Jay's letter to Ann Clwyd MP September 1997, Appendix 1). Despite this, private cosmetic surgery clinics have been targeted by the media and by organisations predominantly representing NHS Consultant Plastic Surgeons with private practice in cosmetic surgery. The media's interest is predictable, but even the most sensational programme makers can find little to criticise in Transform's current practice.

The British Association of Aesthetic Plastic Surgeons (BAAPS) have attempted to turn public opinion against their competitors in the private sector by attacking the qualifications of private surgeons. Despite the fact that private surgeons often have much the greater experience and often make use of more modern techniques, BAAPS members have projected themselves as experts in the field. Interestingly, the public seem unmoved by BAAPS' efforts and continue to choose surgeons who practise their skills in what little time they have left after meeting their commitments to the NHS.

Founded in 1975, the Group will shortly have 16 clinics throughout the United Kingdom and two hospitals, one in Manchester and one in North London.

Transform provides a wide range of surgical and non-surgical procedures for men and women, including breast and facial surgery, fat removal, hair removal, skin peels and injectable wrinkle treatments. It has been estimated that Transform has provided more than 77,000 cosmetic surgery procedures. The number of non-surgical cosmetic procedures is of the same order. Transform's budget for 1999 is £20 million, making it the largest specialist provider of cosmetic surgery in the United Kingdom. Transform provides up to 25 per cent of the breast implants in the private sector. Implants are registered with the National Breast Implant Registry.

Transform currently enjoys the services of 21 surgeons, many of whom are or have been NHS Consultants, Associate Specialists or Locum Consultants. We are also proud to work with a large group of surgeons who have completed many thousands of successful cosmetic surgery procedures, but who have chosen a career outside the NHS.

Transform's clinics and hospitals are registered with local Health Authorities under the Registered Homes Act 1984.

Transform currently employs approximately 300 clinical and non-clinical staff throughout the United Kingdom, many of whom have been with the Company for 10 years or more.

Transform is currently applying for ISO 2000 (formerly ISO 9001/2).

The rapidly increasing demand for cosmetic surgery, the influx of new private clinics and new surgeons (often from Europe) and the recent failure of LST Limited are clear indications that some improvements in regulation are required. Cosmetic surgery cannot continue to be seen as the exclusive property of NHS Consultant Plastic Surgeons operating in their spare time. The pressure on the NHS and on waiting lists is hardly likely to diminish in future years. NHS Consultants will surely find it more and more difficult to divide their loyalties and energies between the public and their private practice in future.

Transform believe that cosmetic surgery must be viewed as a surgical speciality in its own right and that efforts must be made to develop an appropriate regime of regulation and control to safeguard the public and clinicians involved.

January 1999

Recommendations

1. Agree a code of conduct for all organisations and individuals providing or practising cosmetic surgery. (ref: Appendix II)
2. Agree measures to improve clinical standards in cosmetic surgery. (ref. Appendix III)
3. To consider the setting up of a private healthcare regulatory body. The bodies currently responsible for the regulation of our activities are many and various. In our experience, they are over-stretched and under-resourced to provide consistent monitoring of existing regulations across the United Kingdom. Further regulations will clearly compound the situation.

The providers of health care vary from private individuals to major national and international corporations. If regulation is to be meaningful and consistent across the whole sector, it may be necessary to consider a national body to co-ordinate the activities of all concerned.

*22 April 1999]**[Continued]*

APPENDIX 1

Copy of a letter dated 29 September from the Minister of State Department of Health to Ann Clwyd MP

Thank you for your letter of 29 July enclosing correspondence from Mr George Joss of Norwich about the regulation of cosmetic surgery in the private sector. I am sorry you have not received an earlier reply.

As you know, we have reservations about whether any new regulatory body would be helpful in raising overall standards in private cosmetic clinics. This is not to say that a regulatory body would be ineffective, but the potential effectiveness is difficult to quantify. At the moment the evidence does not support anecdotal reports of sub-standard practice in private clinics, or of harm done to patients. The survey carried out by British Association of Plastic Surgeons, at the request of the Department of Health, indicated no significant problem. Only a very small number of patients were identified as presenting at NHS hospitals with conditions associated with possible poor practice in the private sector. There were undoubtedly weaknesses in that survey, but the general message was clear. We also need to recognise that the sums of money likely to be involved in setting-up a regulatory body would be quite substantial and could only be met through commensurate savings elsewhere within the health budget.

There is already a series of checks and balances in place to ensure that patients are protected. Anyone who attempted to perform a cosmetic procedure, but who was not competent to do so, would expose themselves to the risk of civil, and possibly criminal, liability, or to professional proceedings for misconduct. In this respect the General Medical Council has had its powers extended so that it can now instigate disciplinary procedures in cases of alleged seriously deficient professional performance, as well as serious professional misconduct. In addition, the Advertising Standards Authority can ensure that non-qualified people do not falsely advertise themselves as qualified. Finally, the statutory control of the private sector, is provided through a system of registration and inspection, which is wholly delegated to health authorities under the Registered Homes Act 1984.

Our advice remains that anyone seriously contemplating cosmetic surgery in the private sector should check the credentials of the surgeon through the GMC, or through the British Association of Plastic Surgeons or British Association of Aesthetic and Plastic Surgeons.

APPENDIX 2

A CODE OF CONDUCT FOR ORGANISATIONS AND INDIVIDUALS PROVIDING OR PRACTISING COSMETIC SURGERY

Transform recommends the following for inclusion in a code of conduct:

1. The owners and senior managers of all organisations selling cosmetic surgery services should be licensed to operate, having satisfied the authorities that they are fit persons. Licences should be reviewed regularly.
2. Organisations and individuals selling cosmetic surgery to the public, where the patient has to pay in advance, should be obliged to lodge a substantial cash balance in a trust fund or provide a bond to act as security against pre-payments.
3. Patients should be able to obtain a full refund of all moneys paid in advance in the event they wish to cancel their surgery. There should be no preconditions to this policy.
4. All efforts should be made to keep the patient's GP informed of their patient's wishes regarding cosmetic surgery whilst safeguarding the patient's right to confidentiality.
5. The role and qualifications of sales staff should be made clear to potential patients. Sales staff must avoid offering clinical opinions or advice unless they are suitably qualified. All sales staff should be suitably trained.
6. All advertisements for cosmetic surgery services should be approved by the Advertising Standards Authority before they are placed with the media.
7. Organisations and individuals not licensed to operate by their local Health Authority should not be permitted to place advertisements for the sale of cosmetic surgery services.

APPENDIX 3

MEASURES TO IMPROVE CLINICAL STANDARDS IN COSMETIC SURGERY

Despite the fact that there appears to be little evidence of poor practice in the private sector (Ref Baroness Jay's letter to Ann Clwyd MP, September 1997—Appendix I), public confidence has been damaged by sensationalist reports in the media and criticism by the British Association of Aesthetic Plastic Surgery (BAAPS).

*22 April 1999]**[Continued]*

Currently, the only authority to which the public can refer for advice as to the appropriateness of surgeons to perform cosmetic surgery is the General Medical Council (GMC). The GMC will recommend only those surgeons on its Plastic Surgery Specialist Register. BAAPS, supports the GMC view in general, but recommends its own members in particular.

This situation gives rise to several potential anomalies:

- (a) A plastic surgeon on the GMC Specialist Register with less than 50 cases in his/her portfolio could be considered qualified to undertake cosmetic surgery. Whilst a general, ENT, or maxillo-facial surgeon with many years experience and several thousand successful cases could be considered unqualified.
- (b) Suitably qualified plastic surgeons from other European countries can enter the GMC Specialist Register with little difficulty. Entry on this register renders them qualified to practice cosmetic surgery in the United Kingdom regardless of their experience in their own countries. Yet UK general, ENT and maxillo-facial surgeons with several thousand successful cases in their portfolios are considered by some to be unqualified.
- (c) There is a strong body of opinion that unless a surgeon regularly undertakes a sufficiently large number of specific surgical procedures, he/she may find it difficult to maintain and develop the techniques essential to ensure a successful outcome. This was certainly the conclusion of Sir Kenneth Calman when he reviewed the United Kingdom's cancer services. In our opinion this philosophy applies equally to cosmetic surgery. As the NHS has largely ceased providing purely cosmetic breast enlargements, fat removal and facial surgery, one must ask what opportunity an NHS Consultant Plastic Surgeon has to develop and maintain the skills necessary to provide safe and effective cosmetic surgery?

A busy full time private cosmetic surgeon may well perform between 750 and 1,000 surgical procedures per year. This level of experience cannot be matched by the great majority of Consultant Plastic Surgeons, especially in view of their obligations to the NHS.

Impressive and important though it is, in our opinion it is not enough that a surgeon has attained further/higher qualifications. Account must be taken of the volume, frequency and quality of their cosmetic surgery.

- (d) There are many examples of excellent surgeons, not the GMC Specialist Register, successfully undertaking large volumes of NHS "waiting list initiative" plastic surgery. In these cases, NHS Trusts would probably insist that patients are safeguarded, as the surgeon is theoretically under the supervision of a consultant colleague. This approach is clearly open to question and begs investigation and discussion in view of the position taken by the GMC and BAAPS.

In order that the public is further safeguarded and that public confidence is restored, we would recommend the following:

- (i) All surgeons currently practising cosmetic surgery should be assessed by an independent panel. The same regime of assessment should be applied to all surgeons, regardless of their qualifications and without regard to which Royal College they are members of, or which professional organisation represents them.
- (ii) The GMC should compile a Specialist Register for members of the Royal College of Surgeons who can demonstrate that they perform a suitable volume of safe and effective cosmetic surgery annually.
- (iii) Training programmes should be established for surgeons wanting to enter the field and continuing medical education for all practising cosmetic surgeons should be obligatory.
- (iv) Protocols, clinical audit and research programmes should be given a high priority. There are many myths about cosmetic surgery, but few facts.
- (v) Where practical, patients should be given a seven day "cooling-off" period. Operations on the day of consultation with the surgeon should not be permitted without authorisation from the patient's GP.
- (vi) Patients should be provided with written information regarding the procedure they are interested in and should be able to discuss all aspects of their requirements with a surgeon, at no cost to themselves.
- (vii) Patients should be made aware of the clinical and financial implications of the surgery they require.
- (viii) All individuals and organisations providing or practising cosmetic surgery should operate a Health Authority approved complaints system. This system should be monitored by the Health Authority. All patients should have access to the complaints ombudsmen.

22 April 1999][Continued

- (ix) All those providing or practising cosmetic surgery should also provide a 24-hour post-operative clinical service with help-lines, access to surgeons and nursing staff and the facility for domiciliary visits.
- (x) All surgeons should keep up to date portfolios/logbooks of all the procedures provided, including cases of alleged and proven medical negligence. This information must be made available to all interested parties.

APPENDIX 4

COMPLIMENTS AND COMPLAINTS POLICY AND PROCEDURE

AIMS OF THE POLICY

The Transform Medical Group (CS) Ltd aims to provide the same high quality service throughout the group and therefore Transform actively seeks patient opinion regarding the quality of care received from initial contact through to post operative care.

Compliments and complaints are a measure of satisfaction and should be used to improve the quality of service provided.

To this end we will:—

- record compliments and ensure that they are brought to the attention of the staff involved;
- resolve any complaints as fully and speedily as possible. The information gained should be used to improve the quality of our service on a continuing basis.

COMPLIMENTS

Definition

A compliment is an expression of satisfaction from a patient regarding the quality of service provided.

PROCEDURE

- Post treatment questionnaires are forwarded to all surgical patients post operatively. All questionnaires returned are monitored by the Patient Relations Manager, any staff who are especially highlighted will be notified. Copies of all forms are forwarded to the National Manager of Clinical Services and appropriate forms to the relevant clinic manager for retention on the patient file and to the relevant clinician for information.

Any compliments eg cards, letter received locally should be displayed for staff to see.

COMPLAINTS

Definition

A complaint is any expression of dissatisfaction from a patient, his or her representative or any user of the service.

Principles

Transform's complaints policy and procedure will:

- be easily accessible and well publicised;
- be simple to understand and use;
- allow speedy handling within established time limits;
- ensure all concerned are informed of progress;
- ensure a full and fair investigation;
- respect people's desire for confidentiality;
- address all points at issue and provide an effective response;
- provide information to managers so that services can be improved.

22 April 1999][Continued

Time Limit of Initiating Complaints

Transform does not put a time limit on the receipt of complaints.

Procedure

Complaints can be expressed in the following format:

- minor criticisms;
- via the patient questionnaire;
- oral complaints;
- written complaints.

Minor Criticisms

Even those which appear trivial, will be managed sympathetically and it will frequently be possible to provide an explanation and acceptable answer at the time.

Patient Questionnaires

Are monitored by the Patient Relations Manager and any expressions of dissatisfaction should be highlighted to the staff concerned. If appropriate the matter should be investigated and a response sent to the patient. When a patient remains dissatisfied, it will be necessary to use the oral or written procedure, oral complaints should be dealt with locally, all written complaints should be forwarded to the Group Managing Director.

Oral Complaints

When a member of staff receives an oral complaint from a patient, he or she will—

- obtain factual information from the complainant and record it on the patients medical file.
- confirm that the complaint will be dealt with in the appropriate manner.
- ensure the clinic manager/nurse manager (Bowden Hospital) is notified of the oral complaint, outline any action taken or agree action to be taken.
- advise the complainant orally of the outcome of the investigation and what action will be taken where it is not possible immediately to resolve the complainants concerns and note on the medical file.

Should the complainant remain dissatisfied, he or she will be advised to put his or her complaint in writing to the Group Managing Director.

Written Complaints

All patients who wish to complain formally should be advised to write to the Group Managing Director at Transform's Head Office. Written complaints should be acknowledged and then passed to the Patient Relations Manager for investigation.

Straightforward complaints should usually be resolved within 20 working days. More complex complaints may take longer and complainants will be kept informed of progress at regular intervals.

Procedure

A written acknowledgement will be sent within two working days.

The complainant will be informed of how the complaint will be investigated.

All complaints will be logged in the Patient Complaints Register which is held by the Patient Relations Manager.

A copy of the complaint will be sent to the original clinic for record purposes and copies will also be forwarded to relevant staff who will provide a factual written statement and return it to the Patient Relations Manager within 10 working days.

Staff involved will normally be advised of the content of the reply before it is sent.

*22 April 1999]**[Continued*

On completion the complainant will receive a letter from the Group Managing Director containing a full written account of the results of the investigation, an apology for any deficiencies and an explanation of remedial action taken.

Copies of all correspondence will be forwarded for retention on the patient records.

The Patient Complaints Register will be continually updated with details of all new correspondence.

January 1998

Letter from the Group Secretary The Harley Medical Group to the Clerk of the Committee

PRIVATE COSMETIC SURGERY IN THE UK (PM 55)

Thank you for your letter of 17 December. I attach a brief memorandum summarising our recommendations for the private cosmetic surgery sector in the UK.

I thought it might also be useful to give you some background on The Harley Medical Group, and on our perception of the issues facing the private cosmetic surgery sector in the UK.

THE HARLEY MEDICAL GROUP

The Harley Medical Group is a leader in the field of cosmetic and reconstructive surgery and a specialist in treatments involving Class 4 lasers. Established over 15 years ago, it has nine fully staffed clinics nationwide and is regularly appointed by European and US medical equipment companies to supervise European launches of advanced procedures.

THE ISSUES FACING THE UK COSMETIC SURGERY SECTOR

The increased popularity of cosmetic surgery is largely a factor of increased awareness and education. This increased awareness and education has come about as private clinics have sought to inform the public of what they are offering. Recent surveys, and The Harley Medical Group's 15 years of experience in the cosmetic surgery market, clearly indicate that the principal reason that people seek cosmetic surgery is their desire, contrary to general belief, not to stand out in a crowd, but to blend in by looking "normal". The vast majority of patients undergoing cosmetic surgery not only improve their appearance, but improve their confidence and self-esteem permanently.

Someone wishing to have cosmetic surgery can either be referred by a GP to a plastic surgeon or private clinic, respond to a media article or media advertisement, or be referred by a happy patient. Many potential patients find it embarrassing to discuss their cosmetic surgery needs with a National Health GP, who may be unsympathetic to the patient's enquiry, due to the demands on their time for acute patient care. Most potential patients see it as their right to be able to "shop around" for the clinic or surgeon, who is best going to satisfy their needs.

The principal problem confronting the public today is the unprofessional and unethical practices of some clinics offering a cosmetic surgery service. The Harley Medical Group believes that proper guidelines and regulation of the UK cosmetic surgery sector would correct this problem.

I hope that you will find our contribution to be useful. We have sought to keep the memorandum as concise as possible and would welcome the opportunity to meet the Committee in order to give a more detailed account of our thoughts and discuss any of the Committee's concerns.

Group Chairman

19 January 1999

MEMORANDUM

1. EXECUTIVE SUMMARY

1.1 Following the announcement by the House of Commons Health Committee that an enquiry into the provision of private healthcare in the United Kingdom would take place from February 1999, The Harley Medical Group contacted Mr David Hinchliffe, Chairman of the Health Committee, who invited The Harley Medical Group to forward its comments on issues affecting its particular area of operation, namely cosmetic surgery.

1.2 The Harley Medical Group would like to make recommendations based on protocols established across its nine clinics. The Harley Medical Group believes that these recommendations form the basis for achievable reforms and regulations aimed at protecting the patient. These recommendations are as follows:

22 April 1999]

[Continued

- (a) *Qualifications of counselling staff*: pre-surgeon consultations should only be carried out by qualified UKCC nursing staff.
- (b) *Remuneration of counselling staff*: nurse counsellors in the private health care sector should be paid a flat annual salary with no commission-based incentives.
- (c) *Refunds to patients*: patients wishing to cancel their operation should get a refund to the extent that they give adequate notice.
- (d) *"Cooling-off" period*: patients considering an invasive procedure should be encouraged to think about it for at least one week from the consultation with the surgeon.
- (e) *Post-operative support*: regulations should be put in place to ensure that adequate post-operative support and care are provided.
- (f) *Enlargement of the Specialist Register*: The General Medical Council should assess and recognise the specialist skills of non-EU surgeons operating in the UK by giving them access to the Specialist Register.
- (g) *Establishment of a regulatory body for Cosmetic Surgery*: a body regulating surgeons operating in cosmetic surgery should be established, under the auspices of the General Medical Council, with similar objectives to those developed by the UKCC for nurses.
- (h) *Local Health Authority registration*: any clinic providing medical information and advice to the public should be registered by its Local Health Authority to ensure that the interests of the patients are protected.
- (i) *Complaint procedure*: all private clinics should inform their patients of the procedure to follow when making a complaint.
- (j) *Supervision by the Advertising Standards Authority*: the Advertising Standards Authority should supervise more closely the advertising material released by the private healthcare sector in order to ensure that it is accurate and that claims can be backed up with published medical research.

These recommendations are described in more detail in the following paragraphs.

2. QUALIFICATIONS OF COUNSELLING STAFF

2.1 Pre-surgeon consultations are highly beneficial to the prospective patient. The purpose of the initial consultation is to provide the patient with an opportunity to explore his or her interest in a particular procedure and make an informed choice about whether or not to go ahead with a surgeon appointment. We believe that this provides a forum for patients to ask pertinent questions and freely express any concerns, without feeling intimidated about the concept of meeting the surgeon first. This meeting also enables the nurse to investigate whether the patient has realistic expectations of the treatment being discussed. If the patient decides to have a consultation with a surgeon, he or she will be better prepared and able to use the knowledge gained with the nurse to develop a more appropriate and informative discussion with the surgeon. Following their initial consultation, patients have reported to feel much more confident in conversing with the surgeon.

2.2 In the interest of the patients, The Harley Medical Group recommends that these initial consultations should only be carried out by qualified nursing staff working within the guidelines of the Code of Conduct of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting ("UKCC").

3. THE UKCC CODE OF CONDUCT

3.1 The UKCC is a regulatory body for nursing, midwifery and health visiting, which undertakes to ensure that patient care is paramount at all times.

3.2 Its mission is to establish and improve nursing standards in order to serve and protect the public. This organisation maintains a register of qualified nurses, midwives and health visitors and provides them with advice on professional standards. It sets standards for the education, practice and conduct in these disciplines.

3.3 Any registered nurse is required to follow the code of conduct laid out by the UKCC, otherwise risks being struck off the register. Initial consultations at The Harley Medical Group are conducted exclusively by UKCC registered RGN Level One nursing staff.

3.4 Extract from Code of Professional Conduct—Third Edition, June 1992:

- Act always in such a manner as to promote and safeguard the interests and well-being of patients and client;
- ensure that no action or omission on your part, or within your sphere of responsibility is detrimental to the interests, condition or safety of patients and clients;
- avoid any abuse of your privileged relationship with patients and clients and of the privileged access allowed to their person, property, etc.;

*22 April 1999]**[Continued]*

- report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, in any circumstances in the environment of care which could jeopardise standards of practice;
- ensure that your registration status is not used in the promotion of commercial products and services, declare any financial interests in relevant organisations providing such goods or services that your professional judgement is not influenced by any commercial considerations.

3.5 The Harley Medical Group believes that if all pre-surgeon consultations throughout the private healthcare sector were conducted by UKCC registered nurses on a fixed salary, sales tactics would not be adopted and patient care would remain the priority.

4. REMUNERATION OF COUNSELLING STAFF

We recommend that nurse counsellors in the private healthcare sector be paid in a flat annual salary with no commission-based incentives attached to their pay structure. If this were implemented, patients would be entirely confident that the advice from the counsellor was independent, as the counsellors' remuneration would be unaffected by the outcome of the consultation.

5. REFUNDS TO PATIENTS

5.1 It is normal practice for patients to pay for their operation in full before it is carried out.

5.2 Should patients subsequently change their minds and decide not to go ahead with the operation, The Harley Medical Group recommends that they should be allowed to expect a refund as long as they give adequate notice. A refund policy should be put in place across all private practices, taking into account a reasonable administration charge, the surgeons' consultation fee and costs to cover blood and medical testing if appropriate.

6. "COOLING-OFF" PERIOD

The Harley Medical Group recommends that any patient planning an invasive procedure should be encouraged to consider it for at least one week between the consultation with the surgeon and the operation. This would prevent the patient from rushing into a procedure without adequate consideration of issues such as post-operative care, financing etc.

7. POST-OPERATIVE CARE

7.1 The Harley Medical Group recommends that regulations be put into place which ensure that adequate post-operative support and care are provided. Post-operative advice should start at the very first patient consultation, when the nurse counsellor should explain exactly what after care is required and give realistic healing guidelines. The patient should be supplied with written pre and post-operative advice prior to the operation, including diagrams if necessary.

7.2 Following the operation, the patient should have access to full medical and emotional support 24 hours a day through the provision by the clinics of a pager service.

8. REGISTRATION OF QUALIFIED SURGEONS

8.1 There is a shortage of cosmetic surgeons in the UK. As a result, a large number of surgeons come from outside the European Union to practise cosmetic surgery. It is in the patients' interest to be able to satisfy themselves that these surgeons have adequate qualifications.

8.2 In order to be able to practise in the UK, these surgeons are registered by The General Medical Council, but only for their basic medical qualifications. The Harley Medical Group recommends that The General Medical Council should also assess and recognise the specialist skills of these surgeons, who in many cases have been trained to the same standards as British surgeons, by giving them access to the Specialist Register.

8.3 The Harley Medical Group also recommends that a body regulating surgeons operating in cosmetic surgery should be established, under the auspices of The General Medical Council. The role and objectives of this body would be similar to those developed by the UKCC for nurses, namely to develop a code of conduct, monitor the qualifications of surgeons wishing to register and co-ordinate training. At the moment, such a body does not exist in the UK.

22 April 1999]

[Continued

9. LOCAL HEALTH AUTHORITY REGISTRATION

9.1 The Harley Medical Group recommends that any clinic providing medical information and advice to the public should be registered by the local health authorities, to ensure that the interests of the patients are protected by the compliance to strict medical standards.

9.2 In addition, The Harley Medical Group recommends that the same registration requirements as those governing the use of Class 4 lasers be extended to flash lamp machines used for hair removal and the treatment of thread veins.

9.3 Registration with Local Health Authorities would give patients a natural channel to voice their complaints, should they not be dealt with satisfactorily by the clinics themselves. It would also preclude the practice of hiring suites or rooms for adhoc patient consultations and advertising clinic addresses that are not permanently staffed.

10. COMPLAINTS PROCEDURE

The Harley Medical Group publishes a complaints procedure and ensures that it is displayed in the public areas of each of its clinics. The procedure recommends that patients forward their complaints to the clinic manager in the first instance, then to a company director and if deemed necessary by the patient, to the Local Health Authority Registrations Department. The Harley Medical Group recommends that any private clinic should follow the same procedure.

11. REGULATIONS ON ADVERTISING AND PROMOTIONAL LITERATURE

The Harley Medical Group calls for the closer supervision by the Advertising Standards Authority of any advertising material released by the private healthcare sector in order to ensure that it is accurate and that claims can be substantiated or are backed up with published medical research.

January 1999

Examination of Witnesses

MR MEL BRAHAM, Chairman, MR PETER COLES, Company Director, and MRS DIANE HANSEN, Associate Director, Group Director of Nursing, Harley Medical Group, MR DAVID COOPER, Managing Director, MRS ELIZABETH GIBBONS, Marketing Director, and MR JOHN PICKERING, National Manager Clinical Services, Transform Medical Group, examined.

Chairman

695. Could I welcome our next group of witnesses and sincerely apologise for keeping you waiting so long. I am sure that you will have found the previous two sessions interesting and no doubt you may wish to reflect on some of the points that were made in those sessions. Could I ask you to briefly introduce yourselves to the Committee. Can we start with you, Mr Coles?

(Mr Coles) Peter Coles, one of the Company Directors of the Harley Medical Group.

(Mr Braham) Mel Braham, Chairman of the Harley Medical Group.

(Mrs Hansen) I am Diane Hansen, an Associate Director and Group Director of Nursing with the Harley Medical Group.

(Mr Cooper) David Cooper, I am the Managing Director of Transform.

(Mrs Gibbons) Elizabeth Gibbons, I am the Marketing Director of Transform.

(Mr Pickering) John Pickering, Clinical Services Manager at Transform.

696. Can I begin by picking up one or two points that came up in the previous session. I know that some of my colleagues want to go into other directions. Clearly, Mr Cooper, Transform was mentioned specifically in the first session in respect of misleading advertisements. I do feel that it is

important that you have the chance to respond to those comments and make any points that you may wish to make at this stage in respect of what was said about the advertising practices.

(Mr Cooper) Can I hand over to my colleague who is more versed on the issues here.

(Mrs Gibbons) I would like to make a few points in order to bring some of the previous witness' statements into context. Transform Medical Group is the largest specialist cosmetic surgery group in the UK and consequently is most likely to place more advertisements and use more promotional activities than any of the other comparative groups or individual cosmetic surgeons specialising in this field. Consequently I think it is reasonable to assume that complaints that are upheld against the standard of advertising are likely to be in larger numbers with Transform than it is with other cosmetic surgery groups, particularly those who hardly ever place advertisements at all. To get it into context, over the last two years Transform Medical Group—it is a matter of public record—have had seven upheld press complaints against the Group for breaching the code of advertising practice. To get that comment into context they have all originated from complaints from Mr Mohammed. On the whole the complaints are about the grey areas that Mrs Alderson was talking about earlier in her statement regarding the potential to misinterpret the code of practice,

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Chairman Cont]

particularly around the issue of qualifications of surgeons. The distinction between a fully qualified surgeon, a qualified surgeon, an experienced surgeon, a highly experienced surgeon, is a difficult one always to understand. Lately the ASA have brought out some guidelines to help companies like ourselves define the code and, indeed, since we have taken our measures to centralise all marketing activities, and indeed since my appointment as Marketing Director, we have set about getting our house in order substantially by going through the regulatory and advisory arm of the ASA which is known as CAP—the Committee of Advertising Practice—and we have had all of our literature, brochures, adverts, promotional flyers, mailings, individually assessed by CAP to ensure that no further breaches of the code occur.

697. Can I say I am conscious that John Gunnell wants to pursue this matter later on but I felt it important at the outset to give you the opportunity to respond to the points that were made.

(Mrs Gibbons) Thank you for that.

698. I wonder if I can briefly raise one point with the Harley Medical Group. I am not sure, Mr Braham, if you will want to respond. One of the issues that we talked about in the other two sessions was the issue of payment upfront. I am not clear on how this operates but from the evidence we see it is normal practice within your Group for patients to pay for their operations in full before they are carried out. Why is that the practice? What is the reason for that? That seems from what we understand to be the distinction in the particular area of cosmetics that does not apply elsewhere necessarily. What is the reason for that?

(Mr Braham) I think the principal reason, and this is a sector-wide situation, it is not confined to the commercial cosmetic surgery clinics, it applies up and down Harley Street to people in private practice, is the procedure being an elective procedure the results are very subjective and I suspect when the commercial clinics came into existence in the early 1980s they just followed on the practice that had been in place by privately placed plastic surgeons. The difficulty in collecting the money afterwards would no doubt be part of the reason for that.

(Mr Coles) I could not agree more with Mr Braham, that is absolutely the case. It is standard practice.

699. You made the point that the outcome is a subjective judgment and this is an issue that might perhaps be put to people before they pay their money, that the outcome is subjective. This is an area we might talk about in more detail later on. Is it something that you feel is adequately explored with people?

(Mr Braham) It is certainly explained to people. The process that we follow in the patient first having contact with a nurse counsellor is a very important factor in part in contributing to the safety of the patient. In contrast to what was advised earlier by the last speakers, I believe that the nurse counsellor performs a very important role in enhancing and fostering the doctor-patient relationship in that all of our nurses are not on an incentive to ensure that the patient goes ahead and, therefore, the professional

attendance they receive during a counselling session is of extreme importance to the patient. It allows the patient to see the surgeon on much more of an equal term, to have the confidence to ask questions rather than be nervous or in awe, and to develop a proper rapport with the surgeon, which I think is an essential part of the consultation with the surgeon. The decision as to whether the process proceeds from there is a decision made by the surgeon with the agreement of the patient and the patient in our situation at the Harley Medical Group does not pay in full for the procedure prior to the consultation with the surgeon. He pays for the treatment after having seen the surgeon and they both agree it is the right thing to do.

Chairman: I think we might come back to this specific point later on. Could I bring in David Amess.

Mr Amess

700. Will you explain to the Committee how your services are regulated, both internally and externally, and then perhaps of great interest to the Committee, whether you think those regulations are fair and whether your two organisations have any practical suggestions to make as to how those regulations could be changed?

(Mr Cooper) We greatly regret the implication that we are part of a vast unregulated group of private clinics intent on staying outside the reach of the regulatory authorities. Nothing could be further from the truth. On a personal level, I, my board, directors and most of our senior managers are personally vetted several times a year, including our police records and our CVs, by the inspection unit and that is a very regular occurrence. So on a personal level we are monitored very closely and on an organisational level we are broadly subject to the same level of regulation as the large hospital groups are. Health authorities regulate our facilities and, to a large extent, staffing. The Health and Safety Executive regulate our policies regarding health and safety in the workplace. The Environmental Health Authorities regulate our staff, patient facilities and waste disposal. Medicines control agencies regulate our drugs. Through an arrangement we now have with the ASA all our advertising is checked first, and increasingly the GMC MPSMDU are helping to regulate the actions of the surgeons. So we feel that we are thoroughly regulated, though there is always room for improvement, I agree.

Chairman

701. Does any of the Harley Group wish to respond on that?

(Mr Braham) I would concur that the local area health authority do a very good job. They have announced visits, they have unannounced visits and they are very strict with us and we are very happy to comply. We as a group have never had a situation where we have had a licence removed, either temporarily or permanently. All of our clinics are licensed and hereby is an anomaly in the sector, that our clinics are licensed because they either conduct treatment under a local anaesthesia or they have a class 4 laser in them, but there are a number of

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Chairman Cont]

different groups, in fact the vast majority of the industry, I would say, that do not have lasers and do not carry out local anaesthetic work and, therefore, are not regulated and are not registered with a health authority. I think to a large extent it is those people who have brought the industry into disrepute in many ways.

Mr Amess

702. The only thing, Chairman, that I was going to say was that I know that one swallow does not make a summer, but as you, Mr Braham, have already said, it is unfortunate that there does seem to be a little bit of bad publicity about the work which you do, which for many people is very important, and I, as an individual, believe in choice. But have you not, as an industry, got together in some form, because I know the Committee want to explore perhaps later, not today, how to deal with all these, I suppose, "cowboys", because whether you like it or not you are—and I know your Marketing Director mentioned the seven complaints you had had this year -undoubtedly all being tarred with the same brush. So it would be very helpful perhaps for the Committee's deliberations later if you could come up with some suggestion as to how regulation could meet the cowboys?

(Mr Braham) Yes, I would say that you need to discern that this group here is the Transform Medical Group and we are the Harley Medical Group and we are two different organisations, but we have already put forward in our submission the context that we agree that regulation is important and we would welcome it very much and believe that it would place everybody on an equal playing-field, which is important. I think we ourselves follow practices which have stood us in good stead and we put those forward as a possibility and would welcome any further input.

(Mr Coles) I certainly agree with what Mr Braham says and I think in answer to Mr Amess's question also one of the reasons perhaps that all the large cosmetic surgery groups have not got together, we have certainly talked about it often, but it is because of an inquiry like this that it has probably crystallised our thinking and we would now very much welcome that sort of liaison and that sort of getting-together of what we would consider to be the professional organisations in the sector.

Mr Amess: That is splendid news, Chairman. We have, as a Committee, brought them altogether.

Chairman

703. Do you want to add to that, Mr Cooper?

(Mr Cooper) We have talked. It is very definite. We have talked in the past. We need to talk more. There is a whole range of aspects we can cover and we would welcome any assistance to try to bring the industry together. It is very badly fragmented. There are literally thousands of people working from their front rooms in tiny little offices and other places that are not subject to regulation. There are organisations going around calling themselves advisory groups and services when they are not and there are organisations also that we believe act very

unethically. I think one of the problems in the past is that no-one has actually talked to us. No-one has taken the time to try to see it from our side, and I think there is a strong suspicion that because we are different we are worse. I think a lot of people try very hard to demonstrate that without having taken the time to come and talk to us. We have no secrets and if people will come and explore the issues with us we will be delighted to do so.

Dr Brand

704. In medical practice obviously things do go wrong. It is inevitable, and various organisations have tried to work out ways of mitigating against that. The National Health Service is going along the way of clinical governance. The general private hospital tends to have a very rigid accreditation system for the surgeons who work there, with a medical committee which can veto people's admission rights. I am not sure what system even the well organised end of the private cosmetic clinic actually is moving towards?

(Mrs Hansen) With the introduction of NICE and CHI we think that if that could be relayed to the private sector in some way, maybe not via the NHS but through a direct body reporting directly to the Government, or whatever way it was formed, NICE lays the guidelines for those things. I think the clinical excellence, medical audit are very important and something that within the Harley Medical Group we do very much and we believe it is extremely important.

705. Do you publish your audit results and who actually is in charge of audit? In most private hospitals you can identify a medical committee with a chairman and somebody who is responsible for clinical audit, and if they are an enlightened bunch they will publish the results. They do not always. What happens in your organisation?

(Mrs Hansen) We have not published results but we have a medical director who is responsible for the co-ordination of such information and he is also a consultant at a London teaching hospital and, therefore, from both his own experience and also drawing on his colleagues' experience, he is able to audit and gain expertise and use any experience he needs from other people as necessary to do that.

706. How many surgeons do you actually employ on average?

(Mrs Hansen) Approximately ten.

707. Ten?

(Mrs Hansen) Yes.

708. Is there a big change over within that period?

(Mrs Hansen) No, not at all. We have surgeons who have worked with us for over ten years. Essentially we have surgeons working with us who have specialised purely in cosmetic surgery in the main so they are not doing partially plastics or ENT work, or whatever their main speciality may have been initially, but are doing cosmetic work on a full-time basis. Their experience is very extensive.

709. If a patient or a prospective client asks you how many of those procedures has he done and what is the complaints rate, would you be able to tell them?

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Dr Brand Cont]*(Mrs Hansen)* Yes, absolutely.

710. Do you tell them that information is available?

(Mrs Hansen) Yes. You raised another issue as well. I think the nurse counsellor plays a very important part in this. We have talked about people being impartial and is the surgeon impartial in making a decision as to whether a patient should go ahead or not. By having nurse counsellors at the forefront of an organisation like ourselves, which has been a recommendation of the Harley Medical Group, nurses are not commissioned, they are qualified professionals and they are also responsible to a body, that being the UKCC. What they have to do is always act as the patient's advocate. They have to put themselves in the patient's shoes and think "If I was the patient sitting here asking about a facelift then what would I need to be told? What would I want to know? What would be very important?" By having nurses at the front line, and they are not commissioned, there is absolutely no financial incentive at all for the patient to go ahead, they are given that information. At the Harley Medical Group that is the way the process works.

Dr Brand: Presumably they would like to hang on to their job.

Chairman

711. Their employment is an incentive.

(Mrs Hansen) I think you would agree that there is no problem in employing nurses in the country at the moment.

Dr Brand

712. Can I ask whether the Transform Medical Group has the same sorts of policies. The argument that we heard earlier this morning was that the profession has to self-regulate but in the circumstances where they are working in your establishment the interface is between the client and the clinic more than the patient and the surgeon until you get to the point of the surgery.

(Mr Braham) The other thing to realise is that possibly the volume in a commercial clinic is a lot higher than a national health surgeon would receive from GP referrals. From a practical point of view, when you have got 1,000 enquiries a week coming in and a lot of those patients want to come in for information, they do not want to see the surgeon, they do not want to pay any money, they love to see a nurse, they love to have the confidentiality of seeing the nurse knowing that the nurse does the job all day long and is used to doing it and expects them to tell them whatever they want them to tell them in confidence and the patient leaves feeling better for it and more able to make a decision without the pressures of being in front of somebody who they are forced to respect and who they are scared of. If all of those patients were before the surgeon the surgeon would find that he would be wasting a lot of his time, patients would be spending money unnecessarily. There are a lot of time wasters. Unfortunately that is one of the negative things in advertising, you do get a lot of people who time waste, and it would be wrong

to ask them to pay money and it would be wrong for the surgeon to be required to see them until they have decided that they would like to see the surgeon.

713. As you said earlier, the need for cosmetic surgery is perhaps as subjective as its outcome.

(Mr Cooper) I would like to touch on the item that you mentioned earlier about the rank of clinical governance and where responsibility lies. We fully accept clinical governance. We are perfectly happy to get into audit. We have started audit. We have actually shared some information with the department recently hoping to work with the MDA. We are happy to share that information and be collaborative. We have access to some of the largest databases in this area of work and we do not want to be secretive about that. We have got information that we have already started to share. We are in the process of employing a Medical Director. We are keen to get into clinical audit and perhaps my colleague will touch on that in a minute. We fully accept our responsibilities alongside the surgeon and alongside the patient. We never walk away from a problem, we take responsibility. Can I ask John Pickering to mention some of our internal checks and balances.

(Mr Pickering) Just going back to what David said before, a lot of the external regulations actually apply internally as well, things like the Home Acts, pharmacy inspections, and GMC/UKCC also apply internally. We have gathered a lot of data from clinical audit and, as David said, we are appointing a Medical Director to take this on and to produce some papers on it. A lot of the other things we have introduced in the last year to internally regulate ourselves include quality documentation and we are actually piloting the schemes now with various clinics around the country. We have policy and procedure guidelines which we review annually. We also produce strict protocols we should work within. We have risk assessments with every clinic. We have recently developed steering groups to advise on these policies. We also have lead people to look into inspection control, wound care, development of integrated care pathways, standards and bench marking. We have a comprehensive compliments and complaints procedure which identifies all areas' strengths and weaknesses so we know where we are going wrong in the company. We also get a lot of feedback from the patients that we take very seriously. We talk to the patients a lot. We have a network of clinical supervision and support networks for all nurses. We also have an appraisal and performance review which is done in conjunction with the human resource department and this enables control of poor performance. We set performance objectives for all the nurses and the standards are in keeping with the overall strategy of the company.

Chairman

714. Do you have a similar nurse counsellor system as the Harley Medical Group?

(Mr Pickering) No, we do not.

715. So if I came along as a patient who is the person that I would meet first?

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Chairman Cont]

(Mrs Gibbons) I would be happy to answer that question to support the comments that the Harley Medical Group have made. Also in the first line information we ask 30 patient co-ordinators to speak to the patients who respond to our advertisements. Clearly it would not be suitable for a surgeon to take that role.

716. Why?

(Mrs Gibbons) Because they would not be available and would not be keen to do it.

717. Would it not be more appropriate if they were?

(Mrs Gibbons) It would be wonderful, we would love it, but I know that could not possibly happen. There are just too many enquiries. We have 50,000 enquiries a year of our services and I think therein perhaps lies the answer to the question you have just asked.

718. So what is the background of the people who do this interviewing?

(Mrs Gibbons) In the first instance we are talking about telephone advice. Patients are responding to advertisements and they want to know about appointment times, clinic opening times, how quickly can they get an appointment should they wish to do so, which surgeons would be available to see them, what their specific qualifications or skills would be. They are interested in prices, methods of payment, about waiting times and when they can see a surgeon if that is appropriate. They are also particularly interested in the specialist skills of individual surgeons and want to make sure that they are recommended to a surgeon who specialises in the area or the procedure that they are interested in. In that first instance our patient co-ordinators invite patients in to either meet with them or directly to meet the surgeon, this is the patient's choice. Over 20,000 patients elect to come in in the first instance to see a non-clinician who gives this first line advice that I have talked of about methods of payment, advice and waiting times, etc. It is then the patient's choice as to whether they go on to the next stage which is to see a surgeon free of charge. That is a distinguishing difference between the two clinics. I believe Harley Medical Group charge a consultation fee but we actually believe in providing that advice on the surgeon's behalf free of charge. Therefore, we are actively attempting to screen the amount of patients that a surgeon would see down to those who are genuinely interested in pursuing having this procedure if they are deemed to be suitable by the surgeon.

719. Surely the first question the person would ask coming to your clinic would be can you do anything about whatever they perceive their problem to be? If you have advertised showing a picture of the perfect woman surely they come along and say "I do not think I am the perfect woman, can you do something about making me the perfect woman?"

(Mrs Gibbons) I do understand where you are coming from but I have to say that most patients do not want to proceed to see the surgeon to find out whether they will be suitable for a particular procedure until they have at least obtained some idea that they are genuinely able to consider this treatment either in the immediate or in the long-term

future on a financial level. They are embarrassed to go and waste what they perceive to be a surgeon's valuable time if they are completely out of the ball park from the point of view of potentially affording this procedure.

720. One of the concerns we have had expressed to us in evidence has been the way in which, at this first point of contact in a number of private organisations, the patient is seen and possibly seen undressed by somebody who is not medically qualified, and in some respects even examined?

(Mrs Gibbons) I cannot comment on the activities of other clinics and obviously there are small and maybe unscrupulous clinics that may well adopt that policy. I can reassure you, having both worked at the Harley Medical Group and at Transform, that that does not happen in either of our organisations.

721. We got into some discussion with the last two witnesses on the issue of some objective monitoring of the appropriateness of people going through with some cosmetic treatment, and I floated an idea, which has not been worked through and probably will not go any further than this discussion today, that there ought to be somebody objectively looking at whether what this person feels can be done in their circumstances can actually be done, whether they will, indeed, benefit from that. We heard from the Harley Group that you have a nurse counsellor and you get 1,000 enquiries a week. The point I would make and Peter Brand would probably make is that if that nurse counsellor was turning away 999 of them saying, "You look okay as you are. You are not going to benefit from this. There could be problems arising from what you want doing," that nurse counsellor would not be retained in her job, or his job, presumably. How objective is this counselling process?

(Mrs Hansen) I think if 999 were turned away, you used that analogy, which is not going to be the likely case probably in terms of probability.

722. It might be. If one looks at the anxieties, particularly if you take women, about their personal appearance, if one looks at this objectively, without going into the detail of what part of the body they are dissatisfied with, then I suggest it could be 999 who are turned away?

(Mrs Hansen) But I think similarly if 999 were put forward, the chances are a high percentage, or a percentage, of those patients would be unsuitable. Therefore, we would end up with bad publicity and in 15 years the press publicity for the Harley Medical Group, adverse press publicity, has been non-existent because of this role of nurse counsellor. Their ethics in relation to their code of conduct of the UKCC demand that they would not carry out such acts. Their role is to identify the motivation for the patient to go ahead with treatment and to try and give them general advice regarding the treatment and focus really away from the finances to the medical issues and the psychological issues over why they should want to have treatment. Obviously finance is an important thing to them but the really important thing is why they are having it done and what they are hoping to achieve from that and then patients can be discounted or advised to go elsewhere or to take alternative routes if they are not suitable.

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Chairman Cont]

723. But how would you refute the allegation that I think is fairly put to people in your line of business, that you are creating, in many instances, unnecessary anxieties for particularly women but increasingly men, about their bodies?

(Mr Cooper) I do not think we are, Chairman. I must object to that. Let us look at our process. We advertise.

724. You can object to it. I have seen advertisements for a range of different organisations that portray what is apparently the perfect female form. Most women, in my limited experience, do not actually match that.

(Mr Cooper) Chairman, we get male respondents to those advertisements. People are not so naive that they look at this perfect picture that we use to differentiate ourselves from other people in the same areas. If people were that gullible, goodness knows what people would be selling. I take your point that they tend to be glamorised. In our brochure the pictures are not glamorised. If people phone up for a brochure they will see pictures of ordinary men and women and I am sure you have got copies because we have sent them to you. The process for us starts with information, not discussing with someone whether it is appropriate for them to have surgery or not, whether it will save their marriage, whether it will make them more beautiful. The first process for us is informing the potential patient. We give them a patient information pack. It makes clear the role of what we call the patient co-ordinator. It also makes clear that they have absolutely no clinical input whatever. The discussion as to what is appropriate and whether they go forward is a matter for the patient and the surgeon and no-one else.

725. So looking at when this patient goes to the surgeon, do you have any figures within Transform as to how many people, when they have gone through this second stage of seeing a surgeon, actually go through with a process of treatment of some kind? Roughly what percentage would it be?

(Mr Cooper) Of the 50,000 enquiries we received last year, 6,595 people went forward for surgery, a further 5,963 went forward for non-surgery.

Dr Brand

726. That is extremely effective advertising, Mr Chairman, obviously well targeted. May I explore slightly further with Transform this business about clinical audit. You say that you look at the performance of nurses but do also look at the performance of individual surgeons?

(Mr Pickering) I am not a surgeon so I cannot comment on that.

727. Someone has to look at individual performance?

(Mr Cooper) In general, yes, we record their re-admission rates. We are a very small organisation. You mentioned medical advisory groups earlier on. We do not rely on a set-piece medical—

728. They do 6,000—

(Mr Cooper) Over a period of a year.

729. That is not insignificant.

(Mr Cooper) But small in numbers of people.

730. How many surgeons do you employ?

(Mr Cooper) An average of about 21 and there is some coming and going but not much. We have people who have been with us for well over ten years.

731. That is a good sized surgical department which normally would have a director of surgery and would have somebody in charge of clinical standards and certainly audit and I am glad you are now going to appoint one.

(Mr Cooper) The problem is, of course, those people are spread right the way across the United Kingdom. They are not in one place.

732. That is an even greater reason why you should have very good audit mechanisms in place?

(Mr Cooper) We quite agree.

733. Because you cannot rely on NICE or CHI. It has to be internally?

(Mr Cooper) We agree.

734. Have you sacked any surgeons lately?

(Mr Cooper) We do not sack them. This is not just semantics. We do not employ surgeons. It is a relationship where we work together.

735. But you accredit them?

(Mr Cooper) We have parted company.

736. And that does happen?

(Mr Cooper) Yes.

Mr Walter

737. We have talked in that question about NICE and CHI and we mentioned them earlier. Do you think in terms of what those organisations are doing you should come within their remit?

(Mr Coles) Or something certainly like it.

738. But not those?

(Mr Coles) Having read Hansard and particularly the section where the Secretary of State was talking about regulation of the private sector, he actually mentioned the fact that CHI was not the right organisation to register, although an organisation would be set up to do so and that it would be a government regulation rather than a medical health authority regulation. So we appreciate it is going to happen but it will probably not, according to the Secretary of State, be CHI but something like it.

739. The Secretary of State may take a different view after we have made our report.

(Mr Coles) Possibly, yes.

740. He is going to read our report and has to respond to it. We might recommend that. That is why I am interested in your thoughts, whether you think it would be a good idea?

(Mr Coles) We do welcome it, yes. We do genuinely welcome that.

741. So you would like CHI to have a remit that covered your organisation?

(Mr Coles) It would take away the uncertainty of the fact that we are just not regulated at the moment. We are highly criticised. We think we do a particularly good job and we need some sort of ground rules so that we can work to those and people will say, "Well, the Harley Medical Group works to

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Mr Walter Cont]

those, the Transform Medical Group works to those. We accept those and we accept the fact that the company is obviously providing a good service."

(Mrs Hansen) Whilst every clinic of the Harley Medical Group is registered with the local health authority, we constantly hear from them because we are regulated under the Nursing Homes Act. It is not relevant. We are a sort of sub-section and they have to bring in special advisers in relation to lasers and things like that, so to have a specialist branch of CHI relating to private practice would be fantastic in that maybe the regulations would be more appropriate to us, which I think would be helpful to the local health authorities and to ourselves as well.

(Mr Pickering) I think that is a fair point, Mr Chairman, if I might come in. Some of the local inspection units actually come to our organisation and look round the operating facilities and they are more interested to know how much the treatment costs and if they can have some. It is basically because they are unsure as to what they should be inspecting. We deal with patients in the age group ranging between 20 and 40 and they are looking at establishments where the clientele are a lot older.

Chairman: I think we recognise the difficulties with the current regime.

Mr Gunnell

742. You have obviously sat through the sessions already so you have heard the criticisms of advertising practice which was where the discussion started. Do I take it that you both use photographs in your advertisements?

(Mrs Gibbons) If I may answer that question as Transform were cited by name. Transform's simple marketing concepts usually originate from satisfied patients who voluntarily agree to feature as a case study demonstrating their before and after photographs. Our featured patients give their permission and we use their testimony without giving inducements or payments.

743. That is in your brochures?

(Mrs Gibbons) No, that is in our advertisements. I have to say that we try to stay away from using the glamorous model image in order to distance ourselves from the very criticism that has been made about the fact that a glamorous image portraying a beautiful model who clearly has not had cosmetic surgery is hardly a realistic platform on which to promote our procedures. Within our brochure we also use much larger photographs and demonstrate more choice and volume of surgery than we would otherwise choose to feature in an advertisement. That is not to say that we have not ever used models. This has been a recent concept that I have brought about in order to try and identify with real patients about their real needs and to portray the difference that cosmetic surgery can genuinely make using photographs that are untouched and consequently of patients who were just delighted with their results and were prepared to share them with the world.

(Mr Coles) I have noticed some quite amused and wry smiles when the subject comes up of attractive photographs and patients coming to organisations such as ours to "please try to make me even more glamorous". I would like to genuinely say to you that

patients do not normally come and ask us those sorts of questions. They have problems because they feel that there is a part of their anatomy that does not look normal regardless of whether other people think it looks normal—their ears stick out, their nose is crooked, their breasts are too large, their breasts are too small—and it really affects their lives. We have middle aged men coming to us with hair that would be appropriate to a teenager in length and they just want to have their hair cut, they want to look normal. They were teased as children and in 45 years they have never had a haircut to a normal length. The very thought that they can have their ears pinned back to the same level as other people makes an enormous difference to them. They just want to look normal. They do not want to look glamorous, they do not want to stick out in a crowd. They want to conform.

(Mrs Gibbons) I would support that comment that the vast majority of patients who come to see us want to fit in with their looks. There is a whole raft of anti-ageing treatments but it is not necessarily that people are looking to achieve that ultra-glamorous look, it is just that they may want to turn the clock back a little to improve their career prospects or their standing with their peers. Maybe they feel there is something about their appearance, such as eye bags, that give a misleading understanding of whether they drink or sleep easily or they are very tired and haggard and they are attempting to try and do all they can to make their appearance as good as possible.

Chairman

744. Some of us are finding this session very uncomfortable.

(Mr Cooper) A very typical patient, Chairman, is a mother with a couple of children who very often says "I would just like my breasts back". There is no great glamour to that.

Audrey Wise

745. There have been words used like "promotional" and "increased market, creating a market, the market is going to be 200 million". The Harley Group says: "The increased popularity of cosmetic surgery is largely a factor of increased awareness and education". The use of the term "education" is perhaps one that I would want to question. Do you think that you and your advertising have any responsibility or any effect at all on women's perceptions of themselves? I have had two children, I know exactly what you are talking about. It does not seem to me to be helpful or socially responsible to encourage women to think that there is something wrong with them if their breasts diminish after breast feeding two children. In the course of time one's breasts normally come back anyway. Do you not think that the whole concept of promotion and creating a market is undesirable in the context of surgery?

(Mr Braham) Can I perhaps make a comment here?

746. Yes. As many as possible, please.

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Audrey Wise Cont]

(*Mr Braham*) I think in relation to the promotion and the inducement in what you call seductive advertising one needs first to look at the cosmetics industry, cosmetics being applied to the face, etc., the fashion industry, the feel good industry and so on. They have all preceded us. The market for looking better and feeling better as a result of doing something about it was there well before cosmetic surgery became commercialised. I believe all we are doing is meeting a demand that was already there. I do not believe that the Harley Medical Group's advertising is inducing or over-emphasising the fact that if you do not come in you are going to be miserable. In fact, I know that none of our ads say that. I think that good, sensible, honest, non-exaggerated advertising is perfectly acceptable. I think that anything that goes below that is not acceptable, I would accept that.

(*Mrs Gibbons*) If I could reiterate a point with regard to regulation here, the Radio Broadcasting Association and indeed the ITC for television broadcasting and the ASA for press advertising are very clear about how far we can go in the way we promote our services. We must be seen not to play on our patient's securities or potential insecurities about their appearance. We very much try to veer our advertising and marketing activities away from appearing to capitalise on people who may not necessarily have a balanced view about their appearance because they are insecure about it.

(*Mr Braham*) One of the weaknesses of the current system is that there are a lot of organisations who place advertisements with magazines or newspapers or whatever who do not get prior approval for their advertisements and if they are not spotted by somebody like Mr Mohammed then no complaint will come forward and the ad could be there for six or 12 months. I know that has gone on in the past. Maybe some of those ads step over the bounds of being emotive.

747. You are marketing surgical procedures, Mrs Gibbons?

(*Mrs Gibbons*) Yes.

748. And you are promoting surgical procedures, surgical procedures designed to improve the appearance?

(*Mrs Gibbons*) Yes.

749. And yet you seem to be telling me that this does not contain any concept of encouraging people to be dissatisfied with their appearance. You have a member of your staff who in his job description talks about "sales objectives". Can you tell me how you see marketing and what are the sales objectives of your company?

(*Mrs Gibbons*) Certainly Transform aims direct marketing activities to the British public who wish to change something about their physical appearance. At the end of the day I think it is unrealistic to expect us to do that in a format that would perhaps not show good results. I think it is very fair comment that you made earlier in today's proceedings that any glamorous advertisement should be balanced with more information about the up sides and the down sides of having cosmetic surgery because sometimes outcomes are disappointing from a patient's perspective. We have done all we can to create as

much information as possible and make it available to the patient before they make a decision to go ahead with surgery. We could not realistically make the volume of information about the ups and down sides of cosmetic surgery available through our advertisement in the first instance but we can in subsequent information packs and brochures and fact sheets about the procedures in general and we do attempt to do that.

750. I have read your material and I noticed, to be fair to you, that your pack for patients, for instance, on breast augmentation does give warnings and I am glad about that. However, in the research done by the Consumers' Association their incognito researcher at one of your clinics said it was certainly better than some of your competitors.

(*Mrs Gibbons*) I am glad to hear it.

751. She was not talking about Harley, I am not going to enter into that. She said that it was better than some other competitors who are not here, but, nevertheless, the nurse played down the risks involved in surgery.

(*Mrs Gibbons*) Could I ask, did that patient get to see a surgeon?

752. Yes. Rachel said she was interested in liposuction for her buttocks and thighs but they seemed keen to focus on other parts, too. The surgeon said she also had a reasonable bulge round her abdomen and on her knees that he could flatten down a bit, too. The nurse offered a discount, the first area for £2,100, others just £900 if they were done at the same time. I think that is distinctly inappropriate.

(*Mrs Gibbons*) I can understand after reading that why you might make that comment, but our experience is that sometimes journalists do take a little poetic licence when demonstrating that point. I would add that it would not be right for a cosmetic surgeon to attempt to correct a fat-removal problem from a specific area if he could see that the patient would ultimately be disappointed at the end because an area above or below the area that he was being requested to operate on also needed attention. Wherever we can we like to avoid patients having repeat surgery unnecessarily or being disappointed with the result because they were not told, "To get the best of results I should have operated on your hips as well as your thighs." It is our duty of care to point out how and where we will best get the cosmetic surgery result. That is the job of the surgeon, to try and provide the very best possible result at the end of the day. I cannot comment on that individual case.

753. Mrs Gibbons, you and I are both sitting down but I can tell the Committee that I, too, have a reasonable bulge around my abdomen. I would not think that that should make me a candidate for surgery?

(*Mr Cooper*) It would not necessarily, obviously, Chairman. We do provide a very good information pack on lipoplasty which I am sure covers this absolutely fully and if the researcher in question did not get one I am extremely disappointed.

754. Yes. I compliment you on your packs—

(*Mr Cooper*) The pack is there to stop this kind of thing happening.

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Audrey Wise Cont]

755.—both of which I have read, but it is still possible, and it seems to happen, for the discussion to play down those things, on the lines, "Of course, we have to tell you this but it is a great pity and really in practice all these things are very rare." I may say while I compliment you I also think it is probably a bit of self-defence as well because in the event of problems you can point to your packs in writing, but I still compliment you.

(Mr Cooper) Damned if we do, damned if we don't, Chairman, I am afraid.

756. No, I compliment you on your packs but it is not all one way.

(Mr Cooper) No, I agree.

757. But the question of creating a market for your products, your products being surgery, does not seem to give you any problem whatsoever?

(Mrs Gibbons) At the end of the day we market our services, I hope, to a healthy sector of the British public who cannot really buy or achieve our services in any other way other than by coming through the private sector.

758. Mr Braham, you mentioned the cosmetics industry and people trying to improve their appearance. Certainly I wear lipstick and in my young days I went as far as false eyelashes, but are you suggesting that there is a natural continuum between such adornments and actual surgery to alter my appearance, because that is exactly what you seem to be doing and that goes to the heart of the problem? If this is presented as a normal continuum from a bit of powder and paint through to being cut around and having bits put in and bits taken out, that seems a dangerous concept to me. It does seem to be your concept, does it not?

(Mr Braham) No, it does not. It is not meant to imply that. What I am trying to say is that the cosmetics industries have always used images of beautiful people in advertising their products. The fashion industry does exactly the same. They put models on the platform or take photographs of models with clothes on who are slim and beautiful and attractive and they are trying to show their clothes off in the best possible light. Likewise, the cosmetics companies are trying to show their cosmetics off in the best possible light. It has, therefore, been ingrained in children as they grow older and as they grow to adulthood. The movie business, the stars, the actresses, the actors—in all walks of life people try to emulate something that is perhaps a little better. I do not think we can accept responsibility for that. The fact of the matter is that there is a pent-up demand out there. We are advertising. We are advising people that it is available and you can come to the Harley Medical Group if you so desire to have this treatment done. I think the important thing is not to try and stamp on the demand and throw it into the pot and say it is just not there, it is all going to go away. I think the important thing is to regulate the clinics that offer the service to ensure that the public go ahead and are not gullible, that they are well informed, that they are going to be operated on by good surgeons and there is good clinical governance and that proper clinical audits take place. I think that is really the answer to the current problem. There are too many clinics out

there who do not conduct themselves in this manner, who are not registered with any authority whatsoever, who you can say advertise to have 20 or 30 locations around the United Kingdom. They in fact have rooms that are not even open. When it is time to open them a sales lady comes in with a pre-set block of appointments, puts the flowers on the desk and puts a temporary secretary behind the desk and it looks like it is a thriving clinic, conducts the consultation and after the last one she closes the door at night, everybody is gone and there is nobody there for another week or two. It is those sorts of practices that we need to stamp out.

759. I am sure the Committee would certainly agree with that. You nevertheless do think that essentially cosmetic surgery is a business like any other business?

(Mrs Hansen) May I make a point. You have been talking about creating a need and whether or not our advertising is creating a need. One of our nurse counsellors was talking to me about a patient the other day and I think it is probably a relevant case study. It was a 55-year-old lady who had had her children 30 years prior and her breasts had reduced in size at that time and had not come back and for 30 years she had never undressed in front of her husband and it has had an effect on their marriage and on her own self-esteem and well-being. She was applauding the fact that services are now available, whereas 30 years ago they simply were not available. The only person you could go to would be your GP and it was not acceptable maybe in those days to go to your GP and talk about a cosmetic procedure. She was basically so grateful that there was now this service available and I do not think the need has been created. I think we are just fulfilling the need that was there and allowing people the freedom of choice, but that freedom of choice should be regulated, we certainly agree.

760. How would you regulate it?

(Mrs Hansen) A lot of the key points are obviously in our submission. We believe that there should not be anybody liaising with a patient who is anything other than a qualified nurse registered with the UKCC, because we feel that a patient facilitator or co-ordinator or whatever they may be called, the patient comes out of having seen a surgeon and says, "Am I doing the right thing?" or "I forgot to ask him about so-and so." The temptation is for that person to get involved in discussing a medical procedure that they are not qualified to do. So a key recommendation is to have nurses qualified to look after the patient all the way through so that they have a qualified professional with them. The other thing, going back to our colleagues who were talking earlier in terms of registration of surgeons, is that there are some anomalies in terms of how a surgeon can be registered and how a surgeon gets on to the specialist register with the GMC, and there are things that need to be tidied up and put into guidelines and formats to ensure that the general public can see the difference between an able surgeon and one who maybe is not. I think they are two key factors.

761. How do you deal with the fact that being a nurse may actually give a lot of confidence but that nurse's job may still depend on not advising against

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Audrey Wise Cont]

too many operations? Can you, for instance, give us an idea of what proportion of patients who get as far as consultation are discouraged?

(Mrs Hansen) It is approximately 50 per cent of our patients who actually come to consultation who do not go ahead, and not all of those that enquire go to consultation, only a percentage of those do, because they have been advised that either their motivation for surgery is not appropriate or their suitability is not appropriate or there is an alternative route that they may wish to investigate. There is another point in relation to nurses and them holding on to their jobs. There are not enough nurses in this country so there is no desperation for them to advise a patient inappropriately because they need a job because nurses can choose from jobs at the moment, as I am sure you are obviously aware.

(Mrs Gibbons) I do not wish to attempt to in any way denigrate what Diane has said but obviously we do not necessarily use nurses as the first point of contact for our patients and therefore we need to qualify our reasons for not doing so. In our view there could be some difficulty, and I am not suggesting this is the case in the Harley Medical Group because I think we both represent quality organisations, particularly if a potential patient is not clear regarding the purpose of the initial meeting. Consequently very few of our patient co-ordinators who make appointments and give first line advice about costs, etc., and availability of appointments are clinicians. More than the worry about the nurse issue is really the pseudo counsellor who has no specific qualifications or skills or training to give first line advice and who is not necessarily encouraging the patient to go to see the surgeon. That is the role of our patient co-ordinators and I am quite sure it is the role of the nurse advisers at Harley Medical Group, to make an appointment to see the appropriate surgeon. Harley mentioned that they employ ten surgeons and we employ over 20. Clearly there is no point in putting a patient who is interested in breast surgery in front of a surgeon who specialises in liposculpture for example. We want to make the right choices on the patient's behalf and not waste their time and not waste the surgeon's time and make sure that we get the ideal referral service in operation to benefit both patient and surgeon alike.

Mr Gunnell

762. We started in relation to the criticism of advertisements and it is obvious that you feel there are some bad practitioners in the business. One of the things you said to us was that you would like to get the groups together and you wondered whether the Select Committee in its report could help you to get such groups together. Are you aware of groups of those that you would describe as bad practitioners?

(Mr Cooper) We have our opinions and I am sure their opinions would differ but, yes, we are very clear in our minds.

763. You could call a meeting yourselves presumably of all the groups in the light of the Health Select Committee's report on this matter.

(Mr Cooper) I think we would need facilitation, maybe the Independent Health Care Association, maybe the Department. It is important that another

organisation facilitates otherwise you are going to get a lot of clashing interests and in some cases clashing personalities. It is terribly important that a process is set up which is transparent and accessible to other people. We are very, very keen to establish that we have got nothing to hide.

764. Clearly a process of regulation, if it was formulated, would apply to yourselves as well as it would apply to other groups.

(Mr Cooper) Absolutely.

765. It seems to me that it is necessary for a tighter process of regulation to apply to this work.

(Mr Braham) No doubt about that.

(Mr Cooper) We would support that.

(Mr Braham) That would be very welcome.

766. It is in that way that one would be able to sort out the people who are the cowboys in the business.

(Mr Cooper) I think it is possible to put together a code of practice. We have put some ideas forward, financial and otherwise, to safeguard prepayments from patients and a whole range of other issues. We believe strongly that anyone involved in the provision of cosmetic surgery as surgeons should all be assessed regardless of their background or their current roles. There are a number of groups of surgeons who quite legitimately provide a super service. I think that the notion that there are people running around out there who are not qualified is slightly exaggerated. These people would not get medical insurance cover, they would be struck off by the GMC. It is a very complex knotty debate and it needs to be cut through. It is a bit of a Gordian knot and somebody somewhere has got to go bang, right, this is the way it is going to be. There are so many vested interests that I think we need a truly independent guide on this and a lot of dialogue, a lot of talking.

767. When we were talking earlier to the previous group about advertisements they said that they would be quite happy with having to place a warning on all their advertisements to the effect that any medical treatment or surgical treatment carries a risk. Do you place such advertisements?

(Mr Cooper) We do not but we would be happy to.

768. You would be happy to put those words in.

(Mrs Gibbons) I am presently on an advisory group to the Department of Health about improving information available on breast implant surgery. We have talked within that group about the benefit of having quality groups sign up to a code of practice to ensure that we make sure patients are fully aware of both the long-term implications as well as the immediate post-operative complications of having breast implants, the financial implications, the social implications, the psychological implications, and making sure that the up side and the down side is well balanced on the information that we make available. We have talked about some kind of code of practice that quality organisations would feel they would wish to sign up to because it would be in their own interests because the public would perceive that as being a bona fide and creditable and professional organisation to go to if they saw a certain stamp

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Mr Gunnell Cont]

mark that meant something. I think that could certainly be widened as an argument across cosmetic surgery as a whole.

769. Do both groups involve laser technology in their treatment? Are lasers used?

(Mrs Gibbons) We both do get involved in lasers but I think the Harley Medical Group has more extensive experience so perhaps they ought to answer these questions.

(Mr Braham) Yes, we do.

770. Do you have particular regulations for the use of laser equipment?

(Mr Braham) Yes, we do. We are licensed by the area health authority wherever there is a laser.

771. Do you have the proper use of goggles available for both patients and those administering the treatment?

(Mr Braham) Absolutely. Everything is very strictly adhered to. We have a consultant dermatologist who oversees the training of all the nurses who use the lasers, the silica glasses are CC marked specifically for each laser because they are different for each laser depending on the wavelength. We have a very strict code of conduct that relates to the use of lasers and I must say that it works extremely well.

(Mrs Hansen) Professor Blackwell was mentioned earlier this morning. With our clinics in London he is the laser adviser to the health authorities that register our clinics in the London area. On visits to our clinics, announced and unannounced, Professor Blackwell has actually brought trainees with them to show them a model clinic in terms of the procedures we have, our local rules, goggles and everything. We had a visit at our Birmingham clinic on Tuesday this week where a similar comment was made, that coming to an organisation like ourselves which is regulated by the health authority is an enjoyable thing because we are advanced in terms of what we are able to not only offer the patient but also in terms of training and having all the systems in place in terms of maintenance, goggles and all of those things.

(Mr Braham) The Committee needs to be aware that there are other instruments out there that are not called lasers, they called flash lamps, which I consider to be even more dangerous than a laser.

772. I think you described them as high energy light sources and suggested that they are in need of some regulation too.

(Mr Braham) Yes. They are particularly used in the hair removal business and in thread veins. One is called an Epilight, which is a flash lamp situation, and the other one is called Photoderm, or sometimes Photoburn. The end result is that in the wrong hands these instruments are very, very dangerous, they are not very user friendly so it is quite difficult to train somebody to use them and in most instances I do not think they should be used other than by a doctor. They are much more difficult to use than a laser. At the moment they are totally unregulated and, as I speak, they are being placed in beauty salons and used in beauty salons by beauticians who have no training at all.

773. He did mention this and he mentioned that this was an area where regulation was necessary.

(Mr Braham) Absolutely.

(Mr Pickering) We are also regulated by the Health and Safety Executive as well where lasers are concerned. They inspect our premises twice-yearly.

774. He said very frequently the training in the use of such equipment was given by the salesman who came round trying to sell it?

(Mr Braham) That is absolutely true.

775. That is a very unsatisfactory state of affairs?

(Mr Braham) Any organisation that relies on that sort of training does so at their peril. They are dangerous pieces of equipment.

776. So in any recognition of what needs regulating we ought to refer to high-energy light sources as well as to lasers?

(Mr Braham) Absolutely.

Mr Walter

777. I want to go back to the point about advertising and advertising complaints. Mrs Gibbons referred, I think, to seven complaints that have been upheld. Were those seven complaints about the same advertisement or seven complaints about seven different advertisements?

(Mrs Gibbons) No. In fact, they were not against advertisements at all. They were about information that we sent out subsequent to advertisements and Transform have had to do a great deal of work to address that any follow-up literature after the first advertisement is in order. The array of literature that we have had available over the last 23 years is extensive and it has been a very big job, but in the main these complaints are about subsequent mailings after a patient has responded to their first enquiry.

778. So they are seven different pieces of literature?

(Mrs Gibbons) Indeed.

779. Over what period of time?

(Mrs Gibbons) Two years.

(Mr Braham) In our company the situation is that we have had two complaints upheld over 15 years, and to put that into context, last year we placed 5,152 advertisements and in the last three years 12,652, to put that in context.

780. I want to ask another question, which is a statistical question but it is a more general statistical question. It is very difficult in the health service to get any sort of clear statistics about health outcomes, but I wondered if you could tell me—and you might want to provide this evidence at a later stage—how many complaints you get from patients, dissatisfied patients, how many of those result in litigation, which would be settled out of court and how many have been settled in court?

(Mrs Gibbons) I can answer your question in part. We will take a look at 1998 and we will be happy to give you figures to support what I am saying now. We provided in 1998 12,558 procedures. Our compliments and complaints procedure, which is vetted and scrutinised by our health authority, shows that 71 patients out of those 12,558 were disappointed with the outcome of their surgical result, so that obviously that equates to approximately $\frac{1}{2}$ per cent. complaint ratio. I cannot comment on litigation, for good reason. Does that

22 April 1999]

MR MEL BRAHAM, MR PETER COLES, MRS DIANE HANSEN,
MR DAVID COOPER, MRS ELIZABETH GIBBONS
AND MR JOHN PICKERING

[Continued]

[Mr Walter Cont]

answer your question when it comes to trying to get the number of complaints against the amount of good surgery provided in context?

781. You say you cannot comment on the litigation. Is that because you do not know?

(Mrs Gibbons) No, it is not because I do not know. It is really that it would not be appropriate.

(Mr Cooper) We do not have the information with us. I would be more than pleased to share that in private with you, yes.

(Mr Braham) I am quite happy to share the information with you in public. Last year the Harley Medical Group carried out 15,600 treatments. We received 32 complaints, three of which have gone to litigation and will be resolved in the patients' favour.

(Mr Coles) And litigation may mean just a letter from a solicitor.

782. I will leave it there. I am quite happy.

(Mr Braham) In the 15 years we have been in business we have never actually been in court over a patient matter.

(Mr Cooper) All these issues tend to be resolved out of court, which actually is a major problem because people now are well aware of the fact that it is a very litigious society.

783. It would be useful if we could have comparable information from you.

(Mr Cooper) I am happy to share that with you.

Dr Brand

784. Which also means, Chairman, of course, that the General Medical Council does not get involved in any complaints if they are settled out of court. It is one of life's great anomalies really, that these things are not really—

(Mr Cooper) But the insurance companies—

785. The insurance companies would also not inform the General Medical Council unless it is a second or third offence, so it is actually very important that you do your own audit in these matters and vary admission rates accordingly?

(Mr Braham) It is a very difficult area and, as we say, the results are subjective. One person's opinion is of an excellent result and somebody else might give a different opinion. So sometimes they go to litigation on that basis. But it is certainly not to indicate that these patients were badly scarred or that their operation was actually a disaster.

(Mrs Gibbons) Ditto.

786. Do any of my colleagues have any further points before we come to an end? Do any of the witnesses wish to add anything which we have not covered?

(Mr Cooper) Apart from saying thank you very much for giving us the chance to be heard and we would welcome further opportunities.

(Mr Braham) I would endorse that. Thank you very much for inviting us. We would love to be involved in assisting in formulating regulations and would welcome a visit to our premises at any time.

Chairman: May I thank you for your help in the inquiry and apologise that we have gone on so long but I think it has been a very valuable session. We are most grateful to you for your help. Thank you very much.

Supplementary memorandum by Mr Asem Mohammed

COPY OF A LETTER FROM LORD BORRIE QC TO MR MOHAMMED (PM 83A)

Thank you for your letter of 29 March. By the same post I received an acknowledgement of my letter to the Minister. It says: "Staff are examining this issue and we will do our best to report to you within 14 days".

In view of that, I will await a full response before writing to Lord Rodgers.

When I suggested you let me have the examples of misleading advertisements from Cosmetic clinics, I should have specified other ways in which such clinics are misleading people. The further examples you gave me are, like the earlier ones, misleading us in exaggerating the qualities/qualifications of the surgeons. I would like to see any advertisements that are more obviously factually misleading than just hyperbole.

30 March 1999

Letter from the Group Chairman The Harley Medical Group to the Clerk of the Committee (PM 55A)

I am happy to confirm that the transcript of the Select Committee meeting which we attended on 22 April 1999 is correct according to our recollection.

I would like to take this opportunity to reinforce a couple of issues which emerged in what was, in our opinion, a most constructive morning.

To begin with, we fully support the view of Barry Jones, President of BAAPS when he said that it was impractical and unworkable to suggest that all patients seeking cosmetic surgery should be by GP referral. Quite apart from the serious overloading this would cause on the health service—at least 20,000 potential

*22 April 1999]**[Continued*

patients from The Harley Medical Group alone. The most important and relevant fact is that many patients have no wish to bring to the attention of their GP their consideration of elective cosmetic surgery. Although, as a matter of procedure, we always ask patients if we may send on details of their treatment to their GP.

We have long recognised that no matter how moral and honest sales people are, the fact that their earnings are directly affected by the outcome of their consultation prevents them being truly independent when it comes to advising potential patients.

We believe that the refinement of requiring clinics to use only medical or UKCC registered nursing staff would immediately improve standards across the industry and remove the incidence of patient dissatisfaction and media interest.

In addition we are certain that a binding form of registration for all clinics and cosmetic surgery operators would further enhance quality and standards in the sector. Such registration should also be a binding requirement for any clinic wishing to advertise.

In conclusion, I would like to reiterate just how committed we are to the aims and objectives of the Select Committee and would like to offer you and your members free access to any knowledge or expertise we can provide. This includes an open invitation to visit any of our clinics.

4 May 1999

Letter from the Group Managing Director Transform to the Clerk of the Committee

IMPROVEMENTS IN REGULATION WITHIN THE PRIVATE HEALTH CARE SECTOR (PM 26A)

Thank you for the opportunity for Transform Medical Group to give evidence to the Health Committee on Thursday 22 April 1999.

Transform appreciates the interest taken by the committee members in our specialist sector and we were most grateful of the opportunity of sharing our points of view with you all.

After examining the transcript of the Minutes of Evidence, I cannot help but reflect that many of the witnesses statements about the appropriateness of surgeons working in the specialist cosmetic surgery sectors were tainted by commercial and professional self-interest, rather than by a genuine desire to improve and protect "the lot" of the prospective cosmetic surgery patient.

Of the surgeons we have worked with in the last 12 months:

- Four are NHS Consultants on the Plastic Surgery Specialist Register;
- Two are European Surgeons on the Plastic Surgery Specialist Register;
- One is an NHS Consultant on the Maxillofacial Specialist Register;
- One is an NHS Consultant on the Urology Specialist Register;
- One is an NHS ASSOCIATE Specialist in Plastic Surgery;
- One is an NHS Consultant Physician;
- One is an ex-NHS Consultant Breast Surgeon;
- Two are ex-NHS Locum Consultant Plastic Surgeons.

(In addition, we are pleased to work with eight full-time surgeons, specialising in Cosmetic Surgery, with up to 15 years experience and 12,000 cases in their portfolios).

As a consequence of our considerable experience of the work of surgeons from wide ranging backgrounds Transform would be reluctant to be specific about who would be deemed as the "most suitable" to carry out Specialist Cosmetic Surgery procedures.

However, we strongly urge the Committee to consider the real issue of how a member of the British Public is able to obtain information that helps them make the "right choice" when they are considering having a cosmetic surgery procedure.

Information such as:

1. How many cosmetic surgery procedures a certain surgeon has provided throughout his career and in the previous 12 months.
2. How many specialist cosmetic surgery procedures of a certain type a certain surgeon has provided throughout his career and in the previous 12 months.
 - (i) How many liposculpture procedures?
 - (ii) How many facelift procedures etc.

22 April 1999]

[Continued

3. How many of the procedures he performed went well and how many didn't result in a satisfactory outcome.
4. How a surgeon's success rate, or otherwise, compared with other colleagues practising specialist cosmetic surgery.

Transform has provided substantiated evidence to the ASA about describing ourselves as being "the largest specialist cosmetic surgery group in the UK". The ASA are in agreement that we can legitimately make this statement in our advertisements and promotional literature.

Despite the fact that Transform can demonstrate that we carry out more specialist cosmetic surgery than any other individual or group, the present system prevents us from making statements that indicate that our surgeons are expert, fully qualified, qualified, very experienced or even experienced to carry out the procedures that they perform day in and day out and in some cases have done so since our inception 23 years ago. Presently, Transform cannot even describe themselves to be a "leading clinic" or make any claims relating to superiority whatsoever.

We have much sympathy with Ms Alderson's comments describing the ASA's difficulty in understanding the advice the Committee of Advertising Practice have been given by the GMC. The ASA have attempted to give very specific and strict guidelines to companies like Transform and we are grateful for that. However, we feel that the advice and consequent guidelines that have been formulated are desperately biased towards individuals who are not necessarily the most experienced to carry out the procedures they are being promoted to provide.

Surely a surgeon who has 15 years of experience, who performs a large cosmetic surgical list every day of the week and has a fabulous track record for "getting it right" in the majority of cases should be able to describe himself as "very experienced"!

Surely it is equally ridiculous that a foreign surgeon with limited experience because of his young age and lack of opportunity to practice in an unsupervised capacity has been able to enter on the specialist register with the GMC, or gain his CSST in another country, with less vigorous protocols than the UK, but is legitimately termed as both "experienced" and "fully qualified" under the current guidelines laid down by the ASA.

You may be interested to know that Transform have recently declined to work with someone of exactly this calibre because, despite all guidelines that would describe him as otherwise, we know him to be extremely inexperienced and in our view, therefore "unqualified" to operate.

In Transform's view the British Public deserve to be protected from the misinformation that is presently distributed regarding surgeons skills and need real facts on which to base an informed decision.

We would be grateful of any influence you may have in cutting through the bureaucracy that surrounds this debate. We hope your attentions will focus on "how to identify a good cosmetic surgeon from a bad one" and that a fresh and non-commercial solution will arise from your observations and recommendations.

Thank you for your attention to this matter.

28 April 1999

Supplementary memorandum by the Advertising Standards Authority

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTH CARE (PM 14A)

In January 1999, some months before the ASA was asked to provide oral evidence to the Committee, we supplied to the Select Committee a briefing paper outlining our actions in the area of cosmetic surgery advertising. Following the oral hearing last week, at which the Authority's Director General, Mrs Matti Alderson gave evidence, it is clear that we need to emphasise a number of key points. We therefore hope the following information may be useful.

- The ASA acts in the public interest. It administers self-regulatory codes of practice drawn up by the advertising industry. The system operates effectively and proportionately to protect consumers; compliance with the British Codes of Advertising and Sales Promotion stands at around 97 per cent in posters and in magazines and newspapers;
- The effectiveness of the self-regulatory system has been recognised by this and successive governments over the last 20 years. It has been tested in the courts and is also subject to close and regular scrutiny by the DTI and the OFT;
- The ASA is also regularly scrutinised by campaigning groups, and this is as it should be. Some campaigners lie at the extreme end of a spectrum of views so that no regulator could, or should, hope to satisfy them. They may be industry associations, single issue pressure groups or consumer activists. Some argue that the ASA is too restrictive, others that the Authority is too liberal. The fact that the same ASA decision may be criticised equally from both sides suggests that, in general, we achieve a balance between protecting the freedom of commercial speech and safeguarding the interests of consumers;

*22 April 1999]**[Continued]*

- Self-regulation operates effectively within a framework of consumer protection legislation but it is inevitably less effective in sectors where this is inadequate or does not exist. The ASA has worked extremely hard over recent years to resolve problems in cosmetic surgery advertising. The majority of complaints have come from one campaigner. Current compliance levels in the press are now at their best; self-regulation alone is unlikely to effect further improvement;
- Over a six week period, from 8 March 1999, the ASA examined all cosmetic surgery advertisements published in newspapers and magazines throughout the UK. There were no obvious breaches of the Codes. In the 27 instances where we found claims for which companies should hold documentary substantiation, but which had not been tested by an ASA investigation, we sent a Help Note together with a letter advising companies of the Code's requirements;
- The subjective nature both of complaints and advertising claims makes it difficult for the OFT, or Trading Standards Departments, to obtain a High Court Injunction against cosmetic surgery advertisers (under the legal backstop, available through the Director General of Fair Trading the Control of Misleading Advertisements Regulations 1998);
- The ASA considers that terms such as “fully qualified surgeons”, “experienced surgeons” and “consultant” should be defined and enforced by an appropriate medical regulatory authority across all forms of communication—not just advertising. If such claims can be accurately measured and defined the ASA can enforce them effectively but, at present, they represent grey areas;
- We believe a medical regulator should be set up to operate transparently and in the public interest—rather than to protect the interests of its members. It should present an authoritative consensus view rather than sectoral interests. This would allow the ASA to operate more effectively and to seek specialist advice, as it does in most other areas, from an appropriately qualified specialist source;
- We believe private cosmetic surgery clinics should be subject to the same rigorous regulation, and clinical governance as NHS establishments. Data from clinical audits should be available in an accessible form to allow consumers to make informed choices about cosmetic surgery;
- Advertising is generally brand advocacy and by its nature is partial. Advertising must not mislead but it does not provide balanced or objective information about products or services;
- We agree with the Consumers' Association that cosmetic surgery advertising may be unduly influential because there is a lack of impartial information available. This, it must be stressed, is not the fault of advertising. The responsibility for providing objective information about cosmetic surgery should be made readily available to the public by appropriate bodies such as the NHS Executive and the Health Education Authority;
- We believe it is unsatisfactory that the system for regulating advertising content should have to define such clinical terms independently. We believe it is unsatisfactory that the ASA is all that stands between the public and any unscrupulous and disreputable companies that may exist in this sector;
- Commercial decisions made by cosmetic surgery clinics, clinical decisions made by doctors and all communications beyond printed advertising are outside the remit of the Authority. The ASA submit that framework legislation should be introduced to regulate all clinical and commercial practice in addition to communications between clinics and potential patients. Currently, advertising is the only form of communication subject to such regulation in this sector.

10 May 1999

Further supplementary memorandum by Mr Asem Mohammed

REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 83B)

On 22 April Mrs Gibbons was quoted as saying (Q 696) “. . . Transform have had seven upheld press complaints against the Group for breaching the code of advertising practice. . . .” Her statement is slightly misleading. After receiving a complaint, the ASA may decide to investigate a particular complaint formally or informally. Seven complaints have been investigated formally (report published). A number of complaints including complaints about the same advertisement have been informally investigated (breaches of the advertising code but no report published).

The ASA director general was quoted as saying (Q 599) “This is an interesting point. I would want to hear from Mr Mohammed about this”. Ms Aldersen is well aware of the complaint in question. In March 1999 I wrote to the Director of Investigations Mr Roger Wisbey c/o Ms Aldersen.

7 May 1999

THURSDAY 29 APRIL 1999

 Members present:

Mr David Hinchliffe, in the Chair

Julia Drown

Mr John Gunnell

Mr Ivan Lewis

Dr Howard Stoate

Mr Robert Walter

Audrey Wise

Memorandum by the British Medical Association
THE REGULATION OF PRIVATE AND INDEPENDENT HEALTH CARE (PM 41)**INTRODUCTION**

1. The independent sector makes a major contribution to acute medical and surgical care¹, which would produce extreme difficulties for the National Health Service if it had to take on this work. In addition, the independent sector is a major employer and source of foreign earnings. The British Medical Association has always supported alternative methods of providing healthcare, because it is right that in a free society patients should have a choice of healthcare, but we insist that the standards of professional practice in independent healthcare should always be at least as high as in the NHS; it would be wholly wrong for doctors in the private sector to be judged by a lesser standard than their colleagues in the NHS, and thereby to place patients in the private sector at increased risk.

2. We are, therefore, currently encouraging the development of mechanisms for regulating independent healthcare. We believe that these should closely parallel, and in some cases share the methodology of, what is evolving in the NHS. While the solutions that are evolving in the NHS, for example, in the white paper *A First Class Service*², are not necessarily appropriate for direct translation to the independent sector, the time has certainly come for all of those who have an interest in independent healthcare—the medical profession, insurers, independent hospital managers and patients—to come together to develop robust systems for clinical governance in the independent sector.

3. In 1997, therefore, the BMA Private Practice Committee began an initiative to stimulate discussions about the mechanisms to strengthen clinical governance and to monitor and improve the quality of independent health care. Following consultations with insurers, hospital managers and the profession, a discussion paper has been shared with the Private Practice Forum of the Academy of Medical Royal Colleges, and agreement on a set of proposals is imminent. Early in 1999 the BMA plans to host a major conference on the subject.

4. What is proposed is a strengthening of what already exists in many places, and new structures where these do not exist. The aim is to ensure that there are mechanisms in the independent sector to monitor practitioners and facilities in an analogous fashion to the NHS. The proposals are developed from guidance from the General Medical Council about doctors' responsibilities to monitor their own and their colleagues' practice, and from guidance issued by the BMA Central Consultants and Specialists Committee (CCSC) on the roles and responsibilities of NHS clinical and medical directors on handling concerns about the performance of consultants. The fundamental principle which is suggested is that the responsibility to monitor and support individual consultants and specialists should, in the independent sector, be undertaken by the chairman of the independent hospital's Medical Advisory Committee (MAC).

¹ UK national accounts, 1997:

	£ billion	% of GDP
Government	42.7	5.7
Private*	6.3	0.8

*comprises medical products, appliances and equipment (£4.6 billion), out-patient services (£1.5 billion) and hospital services (£0.3 billion).

² A First Class service: Quality in the New NHS. Department of Health, June 1998.

*29 April 1999]**[Continued]*

THE REMIT OF THE SELECT COMMITTEE'S ENQUIRY

5. We welcome the Select Committee's interest in this subject at this time, and particularly the fact that the Select Committee intends to address all aspects of private healthcare; we suggest that, in addition to the areas covered in this evidence, the Select Committee should address alternative treatments, residential and nursing homes, and organisations such as dietary and impotence clinics. However, we are concerned that the remit "to examine . . . healthcare outside the NHS" might exclude private facilities in the NHS such as pay bed units in the NHS hospitals. We suggest in paragraph 23 below a uniform inspection regime for NHS facilities, NHS pay bed units, independent hospitals and any establishment used for medical or surgical treatment. Not only do NHS pay bed units provide vital extra income for the NHS, but at the setting up of the NHS they were an important consideration in ensuring that the best consultants were available to NHS patients, and this remains the case.

CLINICAL FREEDOM IN INDEPENDENT HEALTHCARE

6. The recommendations of the Office of Fair Trading reports on health insurance³ should form a significant area for consideration by the Select Committee. The medical profession is deeply concerned about the intrusion of health insurance companies and private hospital managers into the doctor/patient relationship and the development of "managed care" schemes, which are now seriously discredited in the United States. In private medicine, as in the NHS, the fundamental "contract" is between doctor and patient; if, in the private sector, a "contract" between doctor and insurer is to be superimposed, clinicians' liability to each of the parties must be addressed, particularly where there is conflict. The responsibility of clinicians in independent healthcare is to be clear about their own areas of competence and their professional fees, but their responsibility to communicate with patients about, for example, direct billing arrangements with insurers, approved hospital networks or "package scheme" offers by individual hospitals, whether or not linked to specific insurance policies, is less clear cut. We believe that health insurers must be much clearer with their subscribers, individual and corporate, about the extent of the policies they offer.

MEDICAL ADVISORY COMMITTEES (MACs)

7. All independent hospitals should have a Medical Advisory Committee to represent all of the specialists who have admitting rights to the hospital. In many cases these already exist but they often have very informal constitutions, and not all of the relevant specialties are represented. Consideration must be given to mechanisms for all specialists, including, for example, anaesthetic and diagnostic specialists, to be represented, if necessary by cooption, and all specialties must consider how information is communicated to and from the MAC and within the specialty.

8. MAC members in independent hospitals do not have the same "line management" relationship with the chairman of the MAC as NHS clinical directors have with their medical director. MAC members will, therefore, normally have an advisory relationship with the MAC chairman, but while there are not necessarily the same formal lines of communication as in the NHS, all doctors must bear in mind, and exercise, their responsibility⁴ to monitor the performance of their colleagues and draw attention to any problems that they encounter.

9. MACs should be involved in the development of, and be prepared to take account of, National Service Frameworks (NSFs). The National Institute for Clinical Excellence (NICE) should be asked to address the specific issues of private sector implementation of NSFs, and to involve clinicians working in the private sector in its deliberations.

MAC CHAIRMEN

10. As independent hospitals do not have full time medical directors, or clinical directorates, MAC chairmen in independent hospitals should fulfil a similar role to that of medical directors in NHS trusts in relation to local professional self-regulation, and have regard to the guidance which has been drafted by the BMA on how to carry out these tasks (see Appendix).

11. These new tasks for MACs and their chairmen are considerable, particularly in comparison with what has gone before. They must be given sufficient resources by the hospital management to develop an information and communication strategy of consultation with, and delegation to, appropriate MAC members and specialists using the hospital. The MAC chairman should ensure that information systems are in place which are capable of facilitating clinical audit, performance review and patient documentation. The

³ Health Insurance, Office of Fair Trading, July 1996 and May 1998.

⁴ GMC, Duties of a Doctor.

*29 April 1999]**[Continued]*

enhanced role of the MAC chairman raises the question of whether such posts should be remunerated, and certainly the private hospital will have to provide some form of indemnity against actions which might be brought by any of the parties involved.

CLINICAL AUDIT

12. Clinical audit is a valuable educational tool that can be used by individual doctors acting with their colleagues as part of a clinically-led quality improvement process. In the independent sector, as in the NHS, information gathered from contracting and clinical audit activities can be used as part of a process of monitoring and appraising the quality of the clinical work of the whole hospital, but the collection of audit data and the use which can be made of it differs from the NHS: the numbers of patients per consultant are very many fewer, the numbers of consultants in the same specialty using the hospital will be relatively large, and the case-mix in an independent hospital will be different. The time period to collect meaningful data is, therefore, longer.

13. We suggest that the most efficient method of clinical audit collection in an independent hospital would be on a rolling basis, accumulating morbidity and mortality data on consultants using the hospital, and that this data should be examined at least quarterly by the MAC chairman, who could ask for advice from the appropriate member of the MAC in the event of concern.

14. MACs should be asked to take responsibility for auditing the practice of local specialists in independent practice whether or not they have admitting rights in their hospital. This might require them to develop a process of "certification" of local specialists taking account of appropriate guidance from NICE and the Academy of Medical Royal Colleges.

CLINICAL COMPLAINTS

15. Currently, there is no clinical complaints procedure in the independent sector, despite the fact that in independent medical practice there are more "stakeholders" and the scope for things to go wrong is therefore arguably greater. The present position is that, apart from legal action, the only formal recourse for a patient complaining about clinical care is to the General Medical Council, for processing either through the professional conduct procedure or the new performance review procedure, neither of which is likely to be appropriate as the first recourse for complaint.

16. In the independent sector there should therefore be a formal procedure for patients to pursue complaints about the clinical care they receive which, while it need not be as cumbersome as that in the NHS, should be at least as rigorous. As in the NHS, clinical complaints procedures should be designed to lead to successful resolution of the complaint. In the event of serious concerns about a doctor being investigated and upheld, the doctor could be subjected to withdrawal of admitting rights in independent hospitals, or referral to the GMC, as appropriate. The complaints procedure should, like the NHS procedure, culminate in an independent review. Information about the clinical complaints procedure should be readily available to patients.

17. The pre-action protocol for the resolution of complaints published by the Clinical Disputes Forum in July 1998 might form the basis for some stages of a local complaints procedure in the private sector. However, the Select Committee would be well advised to examine the memoranda submitted to it by the Health Service Commissioner in May and June 1994⁵. These illustrate the difficulty of establishing a process for dealing with complaints involving the exercise of clinical judgment, and suggest some areas in which a private sector procedure might be developed.

NON-CLINICAL COMPLAINTS

18. Because there are so many "stakeholders" in independent health care there is scope for many differences which do not concern the quality of clinical care. The principal "stakeholders" in the independent sector are patients, doctors, insurers and hospitals:

- patients can have cause to complain about the extent of their insurance (if they have it: if not, which is increasingly common, there is even less recourse) or about the facilities of the hospital;
- doctors can have cause to complain about fee levels or poor administration by insurers, or about admission procedures and standards of support in independent hospitals;
- insurers can have cause to complain about excessive professional fees causing their subscribers to have a shortfall in their cover, or about inadequate hospital facilities or pricing policies;

⁵ Memoranda submitted by the Health Service Commissioner, Appendices to the Minutes of Evidence Taken before the Select Committee, Appendix 4 (26 May 1994) and Appendix 5 (27 June 1994).

*29 April 1999]**[Continued]*

- independent hospitals can have cause to complain about aggressive pricing policies by insurers and the behaviour of some doctors.

19. Some insurers will hear complaints from subscribers made to the Insurance Ombudsman, and some through the Personal Investment Authority, and in both cases insurers differ over whether the findings are accepted as binding and whether they will meet the costs incurred by complainants. Independent hospitals vary greatly in their willingness to accept complaints and their capacity to handle them at the appropriate level.

20. There should therefore be agreed arbitration procedures (distinct from the clinical complaints procedure) which are open for use by, and binding upon, all parties. Such a procedure might, for example, where there is disagreement about the level of an individual doctor's professional fee, be used to seek a professional consensus about what is reasonable.

21. All complaints should be resolved locally if possible, but there will need to be some national arbitration body overseeing the procedures (similar to the Health Service Commissioner in the NHS), and consideration needs to be given to the powers of, and funding for, such a body.

INDEPENDENT SPECIALIST PRACTICE OUTSIDE NHS OR INDEPENDENT HOSPITALS

22. The enhanced role of MACs should be extended to all doctors in independent specialist practice, and specialists working outside formal hospital structures should be prepared to answer—to their patients, their colleagues and the public—for the quality of their practice in the same way as those enjoying independent hospital admitting rights, and attention is drawn to the section on inspection of facilities. The BMA suggests that specialists operating outside the independent hospital setting should be prepared to submit their practice to the same processes of continuous professional review and audit as their colleagues practising in hospital settings, and we recommend that MACs should consider coopting representatives of specialists practising locally outside the hospital.

INSPECTION OF FACILITIES

23. Private medical facilities and laboratories should be subject to inspection, and to the same standards, as NHS or independent hospitals. Most pathology laboratories in the NHS and the private sector have been subject to accreditation, and the others should be required to become accredited. However, private hospitals have often complained that the standards of inspection that they are required to meet are not applied to NHS pay bed facilities. There should be national standards and a similar inspection regimen for NHS facilities. NHS pay bed units, independent hospitals and any establishment used for medical or surgical treatment, perhaps based on King's Fund accreditation. The Private Practice Forum of the Academy of Medical Royal Colleges has produced recommendations, but these standards may require to be extended to the clinical governance mechanisms that are in place.

PRIVATE GENERAL PRACTICE

24. Whole-time private general practice is much less common than whole-time private specialist practice, and only in London are there appreciable numbers of whole-time private general practitioners. There are, however, some pressures for an expansion of private general practice, partly as a result of public demand for accessible GPs who can devote increased consultation time but partly also because NHS GPs feel underpaid and undervalued, with the result that some of them are looking for new earning opportunities. Such a trend can only be reversed by paying NHS GPs significantly more, improving their working conditions and encouraging more doctors to go into general practice.

25. It is a matter of concern that the Doctors' Directive (93/16/EEC), which sets out in Title IV the minimum standards of training for general practice, only applies in EU social security systems, rather than to all general practitioners. The result is that UK doctors in private general practice have to meet standards which are less stringent than those expected in the NHS. We would welcome concerted action to achieve similar standards in private general practice as in the NHS, in the interests of higher standards of healthcare throughout the EU. Meanwhile, it would be highly desirable that agencies providing private general practitioner services in the UK should only employ GPs who have been vocationally trained or who would be recognised as having training to an equivalent standard. Until the introduction of the proposed GMC "generalist" register, local medical committees could have an important role in monitoring doctors in independent general practice, while audit and CME might be administered through the local GP postgraduate tutor and postgraduate centre.

26. The development of "walk-in" GP services such as those aimed at London commuters causes considerable concern. While patients' reasons for seeking such advice are understandable, for example when they work some distance from their own GP, the essential prerequisite should be prompt communication with the patient's NHS general practitioner so that the lifetime medical record is properly comprehensive, and to

29 April 1999]

[Continued

enable the provision of safe care. Patients are disadvantaged if the doctors responsible for their treatment are kept in ignorance of essential information, and incompatible advice might be given, to the detriment of the patient.

27. One problem that can arise when patients seek care from both private and NHS GPs is that investigation or referral may be initiated by the private GP without that GP undertaking the counselling and aftercare required. As a result additional and sometimes inappropriate costs may fall on the NHS, which may end up being forced to respond when some elements of care would not have been initiated at all if the NHS had been involved throughout. This particularly occurs if different thresholds for investigation or referral are used in the private sector; one such example may arise in relation to prostatic screening.

APPENDIX 1

HANDLING CONCERNS ABOUT THE PERFORMANCE OF DOCTORS IN THE INDEPENDENT SECTOR: DOCTORS ENJOYING ADMITTING RIGHTS TO INDEPENDENT HOSPITALS

The General Medical Council requirement in "Duties of a Doctor" is that all doctors must "act quickly to protect patients from risk if you have good reason to believe you or a colleague may not be fit to practise".

The BMA believes that this places a clear professional responsibility on doctors working in independent medical practice. Where doctors in independent medical practice have concerns about the performance of colleagues, this responsibility can only be discharged by bringing the matter *formally* to the attention of other colleagues who have the seniority and authority to investigate and resolve the problem.

While the use of informal procedures such as the "three wise men" or counselling services is still to be encouraged in independent medical practice as in the NHS, the GMC guidance contains a clear change of emphasis that, for "ordinary" doctors, merely discussing a concern with a colleague or referring it to such an informal procedure does not in itself discharge the responsibility defined by the GMC. Only if the doctor is fully satisfied after any informal action that the problem no longer exists has his/her responsibility been discharged.

Doctors in independent medical practice have a responsibility to report their concerns about colleagues to the Chairman of their Medical Advisory Committee if they have admitting rights to an independent hospital. It is thus the Chairman of the MAC who carries the main responsibility for action in this area. This responsibility falls into two parts:

ENSURING THAT PROCEDURES ARE IN PLACE

The Chairman of the MAC should ensure that procedures are in place within the hospital/clinic to investigate and resolve all types of performance problems, including those arising from patient complaints, audit results and untoward incidents, as well as from colleagues' concerns. The range of procedures should include:

- informal mechanisms involving peer pressure, eg professional review machinery;
- a confidential procedure to identify health problems ("three wise men" or equivalent);
- a procedure to deal with personal misconduct; this should be part of the hospital/clinic's overall disciplinary procedure, with an investigative procedure with external assessors which may result in withdrawal of admitting rights, and should include an appeals mechanism;
- referral to the GMC Performance Procedure (for cases involving "seriously deficient performance"—defined as a departure from good professional practice sufficiently serious to call into question the doctor's registration);
- a formal disciplinary procedure for use in cases of serious professional misconduct or incompetence which might result in the withdrawal of admission rights (similar to the procedure leading to dismissal in the NHS); such a procedure should allow for appeals from doctors affected;
- an explicit route for colleagues to raise concerns where the subject is the Chairman of the MAC him/herself.

These policies and procedures should be agreed with the medical staff enjoying admitting rights to the hospital/clinic, and should be brought to the attention of all newly recognised specialists, who may be required formally to acknowledge that they have been received.

29 April 1999]

[Continued

CHOOSING AND INITIATING THE APPROPRIATE PROCEDURE

It is suggested that the following principles should be taken into account when making these very difficult decisions:

- having made appropriate enquiries the chairman of the MAC may judge that there is no case to answer; in these circumstances a decision of no further action is legitimate and should be recorded in writing;
- early, informal action may prevent a more serious situation arising in the future;
- where informal solutions are not appropriate, the chairman of the MAC should seek whatever external professional advice is appropriate in establishing the prime facie case, for example, where he/she is not expert in the specialty concerned or where he/she has any personal involvement in the case;
- where the GMC performance procedures are thought to be appropriate, the referral should come formally from the MAC as specified in the GMC's own guidance. Chairmen of MACs will usually wish to discuss such cases, eg with hospital management, but they are professionally accountable to the GMC and carry the responsibility for making the referral;
- the Chairman of the MAC should record at every stage the action that has been taken.

It should be noted that these procedures are designed to deal with "seriously deficient" performance; while their emphasis is remedial rather than punitive a referral will nevertheless be a traumatic event for the doctor concerned and should only be made after a thorough initial investigation, with external advice wherever possible.

The GMC guidance states that "in considering whether conduct or performance action is justified, the screener will normally wish to establish whether any action is already taken by another body or authority—for example, under NHS disciplinary procedures. If such action is being taken, the screener would then have discretion to decide, in the circumstances of each case, whether GMC action should continue, or be postponed until the relevant authority has concluded its procedures. Criteria will be devised to guide screeners in their decision in such cases."

January 1999

Memorandum by Royal College of Nursing of the United Kingdom

THE REGULATION, MONITORING AND INSPECTION OF HEALTHCARE OUTSIDE THE NHS (PM 62)

EXECUTIVE SUMMARY

Inquiry Terms of Reference

To examine the adequacy and extent of the regulation, monitoring and inspection of healthcare outside the NHS. The Committee will also take evidence on complaints procedures in relation to such provision.

Summary of RCN evidence

1. The regulation of health care outside the NHS is determined by Part II of the Registered Homes Act 1984, which covers:

- independent sector nursing homes providing long-term care;
- acute independent hospitals providing both short and long-term care;
- independent hospitals and other facilities providing psychiatric and mental health care, including care for patients detained ('sectioned') under the Mental Health Act 1983;
- independent hospices;
- providers of forensic psychiatric care;
- specialist clinics in the independent sector, including fertility clinics, abortion clinics, vasectomy clinics, hair transplant clinics, clinics for laser treatment;
- complementary medicine clinics;
- any doctors who carry out specially controlled techniques in the independent sector as defined above.

2. The size of the non-NHS health care sector is significant, including:

- over 11,000 beds in 230 acute hospitals, where 20 per cent of UK surgical procedures are conducted;

29 April 1999]

[Continued

- 67 psychiatric hospitals providing over 2,800 beds across the UK;
 - a wide range of specialist clinics including fertility, abortion, vasectomy, hair transplant, cosmetic surgery, laser treatment, and complementary medicine clinics, and those treating eating disorders, alcohol and drug dependencies, depression, personality disorders, and many other psychiatric conditions.
3. Twenty per cent of NHS mental health patients receive their care outside the NHS, mostly in specialist clinics in the independent sector.
4. Fifty-five per cent of NHS medium secure patients are treated in independent sector hospitals.
5. Three-quarters of in-patient hospice care is provided outside the NHS, in 201 voluntary hospices for adults and children.
6. The RCN believes the Registered Homes Act 1984 is outdated, and in need of significant reform.
7. The RCN welcomes the Government's proposals to reform the regulatory system covering long term care outside the NHS, as set out in the *Modernising Social Services* White Paper.
8. The RCN regrets that, to date, the Government have not taken a clear position on the future regulation of the acute independent sector, and is concerned that following the reforms to the regulation of long term care, the acute sector could be left without any statutory regulation at all.
9. The RCN strongly believes that if the Government were to deregulate the acute independent sector (including moving to a system of self-regulation), this would be a disastrous abrogation of responsibility, which would compromise basic standards and safe patient care. Every patient should have the right to minimum standards of quality, care and safety, irrespective of the sector in which they are treated.
10. The RCN believes that the Government now have an excellent opportunity to modernise the overall regulatory system, and create an integrated system which can provide effective regulation for patients receiving care across the full range of sectors and settings. The Government should bring the acute independent sector into the remit of the proposed new independent Commissions for Care Standards.
11. The RCN has identified the following *essential features* which must form part of any new or updated regulatory system for all providers of health care outside the NHS:
- regulation must be statutory;
 - protection of the public must be a fundamental objective of the regulatory system;
 - the statutory system should encompass all independent care provision currently regulated by health authorities and local authorities (including nursing homes, residential homes, and all acute independent sector hospitals and clinics);
 - the statutory regulation system should be extended to include day care, domiciliary care, small children's homes and field social work;
 - the regulatory system, and its inspectorate, must be independent of those being regulated;
 - the independent inspectorate should work to a common framework of nationally-agreed standards;
 - the inspectorate must be multi-disciplinary, including both health and social care professionals, and ensuring a sufficient skill-mix to cover the full range of care providers covered by the regulatory system;
 - there should be training for all registration and inspection officers to nationally agreed standards;
 - the role of the inspectorate should be widened beyond just "policing" to providing support and advice in order to raise standards; there should be a greater emphasis in the regulation process on outcomes and on promoting good practice, including development of indicators of good and bad practice;
 - there should be a clear appeals system, including a conciliatory process, and promotion of the use of mediation prior to appeal;
 - there should be a clear complaints system for patients and users, including the right to appeal to a statutory Ombudsman;
 - patients, users and carers should have greater involvement in the regulatory process than at present;
 - there should be enough flexibility within the statutory regulation system to enable inspectors to be responsive to differing local providers with differing needs.
12. The RCN believes that one integrated regulatory system that applied to all providers of health care outside the NHS would be likely to be more cost effective than separate regulatory systems for different sectors, with the separate infrastructures, administration and staffing that that would entail.
13. The RCN supports the principle that regulation should be self-financing through fee income paid by regulated providers, but would wish to see more detailed analysis of the costs involved.

29 April 1999]

[Continued

14. The RCN believes that any future regulation system for health care outside the NHS should maintain or extend existing open reporting and freedom of information requirements.

15. The RCN would like further clarification about the interface between the independent health care sector and the new National Institute for Clinical Excellence, Commission for Health Improvement, National Service Frameworks, and clinical governance reforms. The RCN believes that such initiatives and bodies will inevitably have an impact on, and interface with, the health care sector outside the NHS, and this, in turn, will have implications for the regulation of the sector.

16. The RCN believes that the Nursing Agencies Act 1957 is outdated and in need of urgent review and reform, in the interests of greater public protection.

1. INTRODUCTION

The Royal College of Nursing (RCN) is the largest professional union of nurses in the world with over 314,000 members. Some 26 per cent of RCN members work outside the NHS, in a variety of settings including nursing and residential homes, independent hospitals, clinics and hospices, nursing and care agencies, and in companies outside the health care sector (eg as occupational health nurses).

The RCN has more than 80 professional forums, which are groups of RCN members who work in related fields. RCN forums include INFORM (the Forum for Independent Sector Nurse Managers), the Forum for Nurses working in Registration and Inspection in the Independent Sector, the Nursing and Care Agency Managers' Forum and the Forum for Hospice and Palliative Care Nurse Managers. All of the above forums participated in formulating this submission.

2. CURRENT REGULATORY SYSTEM FOR HEALTHCARE OUTSIDE THE NHS

Part II of the Registered Homes Act 1984 requires independent sector "nursing homes" and "mental nursing homes" in England and Wales to register with health authorities (on behalf of the Secretary of State). The Act gives "any person authorised in that behalf by the Secretary of State" the right to enter and inspect such homes, and to refuse or withdraw registration if certain criteria are not met. Under regulations stemming from the Act, inspections are carried out at least twice a year by Health Authority Registration and Inspection Teams, and certificates of registration (also known as licences) issued or renewed following a successful inspection⁶.

The Registered Homes Act 1984 gives rather broad definitions to "nursing homes" and "mental nursing homes". NHS and local authority premises are not covered. *Mental nursing homes* are defined as any premises used for:

- the reception of, and the provision of nursing or other medical treatment (including care, habilitation and rehabilitation under medical supervision) for one or more mentally disordered patients, whether exclusively or in common with other patients.

Nursing homes are defined as any premises used for:

- the reception of, and the provision of nursing for, persons suffering from any sickness, injury or infirmity
- the reception of pregnant women or of women immediately after childbirth
- the carrying out of surgical procedures under anaesthesia
- the termination of pregnancies
- endoscopy
- haemodialysis or peritoneal dialysis
- treatment of specially controlled techniques, as specified by regulations⁷. The Secretary of State can specify as a specially controlled technique "any technique of medicine or surgery (including cosmetic surgery) as to which he is satisfied that its use may create a hazard for persons treated by means of it or for staff of any premises where the technique is used." One specified technique involves any treatment using lasers

Given the broad definitions described above, Part II of the Registered Homes Act 1984 in practice covers the following:

- Independent sector nursing homes providing long-term care
- Acute independent hospitals providing both short and long term care

⁶ A Parliamentary Written Answer from Alan Milburn MP revealed that six registrations under Part II of the Registered Homes Act 1984 were cancelled in 1996, 15 in 1995, seven in 1994, 11 in 1993, and seven in 1992. There is no breakdown between the long term and the acute sectors, *Hansard* 16 Jan 1998.

⁷ The Nursing Homes and Mental Nursing Homes Regulations 1984 (SI 1984/1578).

29 April 1999]

[Continued]

- Independent hospitals and other facilities providing psychiatric and mental health care, including care for patients detained (“sectioned”) under the Mental Health Act 1983
- Voluntary hospices
- Providers of forensic psychiatric care
- Specialist clinics in the independent sector, including fertility clinics, abortion clinics, vasectomy clinics, hair transplant clinics, clinics for laser treatment
- Complementary medicine clinics
- Any doctors who carry out specially controlled techniques in the independent sector as defined above

In **Scotland**, nursing homes are regulated by the Nursing Homes (Registration) Scotland Act 1938, and the Social Work (Scotland) Act 1968, as amended by the Registered Establishment (Scotland) Act 1987. As in England and Wales, these Acts also cover regulation of the acute independent sector.

In **Northern Ireland**, nursing homes are regulated by the Registered Homes Northern Ireland Order 1992. There are very few independent acute hospitals in Northern Ireland, and Northern Ireland already has joint inspection units.

The number of health care providers covered by this system of regulation is clearly sizeable and significant. In addition to the UK’s 6,400 nursing homes, there are 230 independent acute hospitals with over 11,000 beds, in which approximately 20 per cent of all surgical procedures performed in the UK are undertaken⁸. A further 67 independent psychiatric hospitals provide nearly 2,850 psychiatric care beds across the UK⁹. 20 per cent of NHS psychiatric patients are treated in specialist independent sector clinics, for example clinics specialising in the treatment of eating disorders, alcohol dependency, drug dependency, personality disorders, depression and post-natal depression. Fifty-five per cent of NHS patients needing medium secure facilities receive their treatment in the independent sector. Three-quarters of in-patient hospice care in the UK is provided by 201 voluntary hospices which are registered charities¹⁰.

3. THE NEED FOR REFORM OF THE REGULATORY SYSTEM

The RCN welcomes the fact that the need to review the regulation, monitoring and inspection of healthcare outside the NHS is starting to be addressed by politicians and policy-makers. The current regulatory system is far from ideal. The RCN has long argued that the Registered Homes Act 1984 is out-of-date, and that significant reform is needed to ensure a regulation system that works effectively to provide protection for all patients within a complex environment encompassing an increasingly diverse range of care providers.

The Government have made clear their intentions to improve the regulation system for independent nursing and residential homes, by setting up the Better Regulation Task Force which published a report on *Long Term Care* in May 1998, and more recently by publishing the White Paper on *Modernising Social Services*. The RCN welcomes the Government’s intention to create a single regulation system through the new Commissions for Care Standards, which will cover both residential and nursing homes (as well as children’s homes, domiciliary social care providers, independent fostering agencies, residential family centres and boarding schools).

The RCN regrets however that, to date, the Government has not taken a clear position on the future regulation of the acute independent sector. The regulation, inspection and registration of acute independent sector providers currently seems “tacked on” to a system designed primarily for the regulation of providers of long-term nursing home care.

The White Paper on Quality, *A First Class Service—Quality of the New NHS* (June 1998) stated that “we are currently looking at options for the future regulation of the independent acute sector.” The White Paper *Modernising Social Services* (November 1998) says “The Government is considering how best to deal with the regulation of the independent acute health sector which is currently regulated on the same basis as nursing homes.” However, there has been little indication of Government thinking, and seemingly no attempt to knit the proposed reforms to the regulation of long term care with any reform of acute independent sector regulation. The RCN is concerned that following the proposed reforms to the regulation of long term care, the acute independent sector could be left without any statutory regulation at all.

Furthermore, some providers do not fall within clear-cut definitions of either nursing homes or acute hospitals. Tadworth Court, in Surrey, is a children’s rehabilitation hospital where children cared for include those recovering from road accidents, and those with cerebral palsy. The hospital does not have an operating

⁸ Source: Laing and Buisson, September 1998.

⁹ *Fitzhugh Directory of Independent Healthcare and Long Term Care: Financial Information*, 11th Edition 1997–98, Health Care Information Services, 1997, London.

¹⁰ *Directory of Hospice and Palliative Care Services in the UK*, 1997, and information provided by the National Council for Hospice and Specialist Palliative Care Services, Jan 1999.

29 April 1999]

[Continued

theatre, and it is therefore unclear whether it would be viewed as an acute hospital, or as a nursing home, under the proposed new regime. Similarly, there are a number of independent sector Brain Injury Units, which could also be defined either as nursing homes or as hospitals. Some independent sector hospitals have long-term beds as part of their registration, and these will come within the remit of the Commissions for Care Standards, whilst other parts of the hospital might remain unregulated under current proposals. Some acute medical and mental health hospitals also contain a mixture of long term and acute beds. There are likely to always be such "grey areas" in the boundaries between nursing homes and acute hospitals, and only a comprehensive regulatory system covering the whole of the independent sector can address this problem.

The RCN strongly believes that if Government were to deregulate the acute independent sector, this would be a disastrous abrogation of public responsibility, which would compromise basic standards and safe patient care. Every patient should have the right to minimum standards of quality, care and safety, irrespective of the sector in which they are treated. The RCN believes that it is imperative that the basic "safety net" which the regulation system provides must be maintained, and indeed improved, for the significant minority of patients who use hospitals, clinics, hospices, and other acute facilities in the independent sector. Far from abolishing acute independent sector regulation, the RCN believes that the Government now have an excellent opportunity to modernise the regulatory system overall, creating an integrated system which can provide effective regulation for patients receiving care across the full range of sectors and settings.

The RCN welcomes the Government's proposals, set out in the *Modernising Social Services* White Paper, for a new, independent system of inspection and regulation, comprising regionally-based Commissions for Care Standards, and covering residential and nursing homes, children's homes, domiciliary social care providers, independent fostering agencies, residential family centres, and boarding schools. The RCN strongly supports the idea that the workforce of the Commissions for Care Standards should comprise people from both health and social care backgrounds, and that their work should be integrated in multi-disciplinary teams. However, the RCN believes that it is vital that, in the interests of patient safety, the acute independent sector remains regulated, and believes that the best way to do this would be to bring the acute independent sector into the remit of the Commissions for Care Standards.

4. ESSENTIAL FEATURES OF AN UPDATED REGULATORY SYSTEM

The RCN has a long-standing and active interest in regulatory systems and policies designed to protect patients and people with care needs, irrespective of whether their care is delivered in the independent or public sector. The RCN has made submissions to many previous consultations on this subject, including the Burgner Report¹¹. The RCN has identified a number of essential features which we believe must form part of any updated regulatory system:

1. regulation must be statutory;
2. protection of the public must be a fundamental objective of the regulatory system;
3. the statutory system should encompass all independent care provision currently regulated by health authorities and local authorities (including nursing homes, residential homes, and all acute independent sector hospitals and clinics);
4. the statutory regulation system should also be extended to include day care, domiciliary care, small children's homes and field social work (it is acknowledged that the White Paper *Modernising Social Services* addresses the majority of these);
5. the regulatory system, and its inspectorate, must be independent of those being regulated;
6. the independent inspectorate should work to a common framework of nationally-agreed standards;
7. the inspectorate must be multi-disciplinary, including both health and social care professionals, and ensuring a sufficient skill-mix to cover the full range of care providers covered by the regulatory system;
8. there should be training for all registration and inspection officers to nationally agreed standards;
9. the role of the inspectorate should be widened beyond just "policing" to providing support and advice in order to raise standards; there should be a greater emphasis in the regulation process on outcomes and on promoting good practice, including development of indicators of good and bad practice;
10. there should be a clear appeals system, including a conciliatory process, and promotion of the use of mediation prior to appeal;
11. there should be a clear complaints system for patients and users, including the right to appeal to a statutory Ombudsman;
12. patients, users and carers should have greater involvement in the regulatory process than at present;

¹¹ *The Regulation and Inspection of Social Services*, Tom Burgner, July 1996.

29 April 1999]

[Continued

13. there should be enough flexibility within the statutory regulation system to enable inspectors to be responsive to differing local providers with differing needs.

Statutory regulation and public protection

The RCN believes that only a statutory regulation system can provide the degree of compliance and consistency needed to minimise unnecessary risks to people's lives, health and well-being. The purpose of the regulation system is to protect the public by ensuring that the basic standards required for adequate and safe patient care are met and maintained. The statutory regulation system provides a basic "safety net" for patients; the kinds of issues covered by the current regulatory system under the Registered Homes Act 1984 include: systems for patient consent; resuscitation provisions; deceased patient procedures; food handling procedures; prevention of infection; drug administration; equipment; staffing levels; record-keeping; complaints procedures; meeting fire, health and safety, radiation protection and environmental health regulations, and the provision of water, electricity, light, heat, and ventilation¹².

The RCN believes that it is important to distinguish between the "safety net" function of statutory regulation, and the function of voluntary quality assurance schemes such as Health Quality Service (previously King Fund Organisational Audit). Investors in People or ISO 9002. Quality assurance schemes promote good practice, over and above the standards required for registration. In practice, it is the larger companies, rather than small clinics, which have been most active in joining quality assurance schemes, as these larger companies are the ones which have the resources to enable them to take part in such schemes. Furthermore, membership of a quality assurance scheme is now a requirement for joining the Independent Healthcare Association, to which all the "big players" in the independent sector are signed up. Membership of a quality assurance scheme is used by many independent sector providers to demonstrate higher standards of care, and is often publicised in their marketing and promotion material, whereas meeting statutory registration requirements is clearly a prerequisite for business operation. Although believing that schemes which promote good practice and quality care are to be encouraged, the RCN believes that they serve a very different purpose to statutory regulation, and should not be seen by Government as an acceptable alternative to a comprehensive and rigorous statutory regulation system.

Scope of regulatory system

There is a general agreement that any system directed towards regulating both long term and acute care should protect the vulnerable public. To give just two examples, the 1996 Burgner report on *The Regulation and Inspection of Social Services* stated that the regulatory framework for protecting people with care needs "should cover all the main services where vulnerable and highly dependent people spend significant amounts of time". And a report on *Regulating Long Term Care: proposals for a Single Registered Care Home* prepared for the Joseph Rowntree Foundation (November 1996) says "it has already been argued that the general case for regulation and promoting quality through inspection is justified by the vulnerability of the clientele for continuing care".

Such statements seem so commonsensical as to be beyond controversy, yet to date, many groups of vulnerable people have not received the protection of the regulatory system. The RCN strongly supports the Government's intention to bring domiciliary care, small children's homes, and local authorities' own residential and children's homes within the scope of the regulatory system for the first time. However, in reforming the system in this much-needed way, the Government may be allowing other groups of vulnerable people to be put at risk, if it allows the acute independent sector to become deregulated. As stated above, those who use the acute independent sector include many with psychiatric and mental health disorders (including a fifth of all NHS psychiatric patients), the terminally ill, people undergoing fertility treatment, abortions, vasectomies, laser treatments, cosmetic surgery, and a wide range of surgical procedures.

The RCN is particularly concerned that, if the acute independent sector were deregulated, this could lead to the growth of small, unscrupulous "cowboy clinics", operating with very poor and sometimes unsafe standards. These would be likely to include abortion clinics, fertility clinics, clinics carrying out circumcision, cosmetic surgery clinics, walk-in medicentres, sports injuries clinics, and complementary medicine clinics. Some might be owned or run from overseas, making sanctions even more difficult in the case of complaint or wrong-doing. The bigger providers, with large market-share, significant resources, well-established reputations, and ongoing quality assurance programmes already in place, would be much more likely to continue as they have done to date, without any reduction in standards. The RCN would also like to see the regulatory system cover private beds based within NHS hospitals, which account for 17 per cent of the acute independent market¹³.

¹² Independent Acute Hospitals and Services, Supplement to the Handbook on the Registration and Inspection of Nursing Homes, NAHAT, 1993.

¹³ Source: Laing and Buisson, September 1998.

*29 April 1999]**[Continued]**Independence*

The RCN believes that the regulatory system must be independent of those it is set up to regulate. The RCN is aware that, under the present system, the line of professional accountability for nurses is disjointed in some areas of registration and inspection. With the advent of the Commissions for Care Standards, the RCN would support the adoption of a protocol to ensure that the issue of accountability for all those involved in the regulatory process is addressed. It is envisaged that this approach would pay particular regard to the accountability of health and social care professionals.

The RCN is also aware that registered nurses working in the independent sector can sometimes encounter a conflict of interests between their professional accountability under the UKCC Code of Conduct, and their business accountability (eg where a nurse is required by her or his employer to adopt practices because of business or financial imperatives that she or he considers conflict with the Code of Conduct). The RCN believes that it is important to recognise the pressures that some nurses are being put under because of these conflicts of interest.

National standards and promoting good practice

The RCN has argued for some time that the present regulatory system has been unacceptably inconsistent, both in the way that the registration function has been administered, and the way in which patient care-delivery has been inspected and monitored¹⁴. The need to address inconsistencies has become even more evident following the changes in care provision nationwide. The RCN believes that nationally agreed standards are essential to overcoming these inconsistencies and ensuring that patients can receive the standards of care they are entitled to expect, irrespective of where they receive their treatment. National standards would also help patients to gain a clearer idea of the standards of care to which they were entitled.

The RCN believes that regulation should be seen as a holistic process, which includes registration, inspection and enforcement. Viewing regulation as holistic means seeing that at its most effective, regulation goes beyond a mere policing function, to one which can provide advice and support to care providers to help them to improve standards. The regulatory process should focus more on outcomes, and on quality not just adequacy. Many of the RCN's members who are involved in registration and inspection want to be able to use their skills and expertise to help improve standards of care and promote good practice, rather than simply ticking off checklists or removing providers from the register. The RCN believes that the role of registration and inspection officers should explicitly include this advisory function, and their training should reflect that. Any legislative changes that are introduced to create a new inspectorate should also reflect this wider, more constructive role.

Benchmarking—the practice of comparing your standards against those of other organisations—is becoming an important part of the drive to improve quality, and should be both encouraged and facilitated by the inspectorate. Work is already underway to develop benchmarking in a number of areas, including some for hospices and for acute hospitals in the independent sector.

In addition, more work needs to be done to raise the quality and standards of inspections themselves. Whereas the Social Services Inspectorate has played a part in trying to improve local authority inspection units, health authority inspection units are not subject to any formal nationalised audit.

Training and skill-mix of the inspectorate

The development of a new regulatory system provides the opportunity for a timely review of the skill-mix and training needs of registration and inspection officers. The RCN is aware that, under the present regulatory arrangements, independent acute sector providers often find themselves being inspected by inspectors whose expertise is in long term care, and who are neither adequately knowledgeable nor properly trained to inspect acute care providers. The problem is compounded as there is currently no agreed or required training for inspectors. Being inspected by someone who lacks the necessary understanding or expertise is extremely frustrating for providers, but even more seriously could lead to oversights, inadequate inspections, and patient care being compromised.

The reform of the regulation system should be taken as an opportunity to address this deficiency. The staff of the new Commissions for Care Standards will need to have a wide range of backgrounds and expertise, as well as thorough training to nationally agreed standards, to equip them to be able to deal with the full spectrum of care providers that they are charged to regulate. The RCN believes that the inspectorate should not be skewed towards a social care or a health care bias, but should involve professionals from both health and social care backgrounds working as equal partners in multi-disciplinary teams.

¹⁴ *An Inspector Calls?*, RCN, August 1994.

*29 April 1999]**[Continued]*

The nursing contribution to the regulation of care provision has been immense, and the RCN believes that nursing will continue to have an important and necessary contribution to make to the new Commissions for Care Standards. Their clinical training and thorough understanding of patient care and quality issues means that nurses will form a vital part of the multi-disciplinary inspection teams. There should be qualified nurses with the appropriate skills at all levels in the regulation function, and in particular, nurses with the appropriate qualifications and skills (eg RMNs for mental health care providers, etc) should be members of the teams monitoring every care home and acute sector provider.

National training would play an important part in harmonising standards and approaches to inspection. Tom Burgner's report recommended organised training for registration and inspection officers "so as to develop common approaches and attitudes towards regulation at local level". The RCN has commenced work on the training and skills-set needed by registration and inspection officers, and would welcome the development of an accredited competency-based training programme for inspectors.

The considerable regulatory expertise which already exists within local authorities and health authorities, together with validated joint training programmes already in place such as the degrees programmes at the Universities of Anglia and York provide a starting point from which to develop a national award. Subjects covered could include: intra-agency and inter-agency collaboration and liaison (from a starting point of shared values); identification and application of national benchmark standards: exercising flexibility at local level; evidence-based standards of good practice, and financial awareness to assist the cost-effective use of resources. A "national curriculum", with a common core content, would aid team-working between inspectors with different backgrounds and help break down professional barriers. It would also provide inspectors with a substantive learning/skills-set and contribute to the expertise, credibility and professional development of the inspectorate. The RCN understands that work has begun on this within the Department of Health, and believes that it is important to consult with all relevant professional and interested groups.

Appeals system

The RCN believes that the system of inspection and regulation should have a clear appeals system, for providers who query or disagree with an inspection report. However, the RCN hopes that the development of nationally agreed standards and greater consistency in the inspection process would lead to a reduction in the number of appeals being made. The RCN also believes that the appeals system needs to incorporate mediation and conciliation processes, enabling providers and the inspectorate to work together to address and resolve problems without having to go through all the stages of a formal appeal. Obviously, where such processes are unsuccessful, there will still be a need for formal appeals.

Complaints system

The RCN believes that a clear complaints mechanism is an essential part of any attempt to deliver high quality care. Not only should all individual providers have internal procedures for dealing with complaints, but the system of regulation and inspection should also include mechanisms for dealing with complaints, but the system of regulation and inspection should also include mechanisms for dealing with complaints by patients and their families about the services being regulated. Information should be produced specifically for patients, users, carers and their families about the complaints mechanism and how to use it, and made readily available. Responding promptly and accurately to patients' complaints should be seen as imperative. Another idea to consider is whether an independent review panel should be set up, which patients would be able to appeal to once internal complaints procedures were exhausted.

Patients should have the right to have their complaints referred to an Ombudsman if neither internal complaints procedures, nor the intervention of the inspectorate, (nor possibly the independent panel), can resolve the situation. The RCN welcomes the proposal in the Modernising Social Services White Paper that there will be recourse to an Ombudsman for complaints against a Commission for Care Standards' exercise of its duties.

At present, independent sector patients do not have access to the Health Services Commissioner (Ombudsman). However, under the present regulatory system, there are a number of options available to dissatisfied patients, beyond complaining to the hospital or clinic itself. Patients can complain to the health authority with which the provider is registered. The fact that acute independent sector providers are licensed by health authorities also means that they are included in the remit of Community Health Councils (CHCs), which act as a "patients' watchdog" although this needs to be made clearer as many patients and some CHCs themselves seem to be unaware that CHCs' remit covers the independent sector.

If the independent acute sector were deregulated, then there would no longer be any mechanism within the health care system for complaints to be independently judged or investigated. Instead, patients would have to embark on individual litigation, which can involve enormous cost and personal stress. Similarly, there would seem to be no mechanism under deregulation by which disreputable and dangerous hospitals and clinics could be closed down. The only option would seem to be that Trading Standards Officers could become

29 April 1999]

[Continued

responsible for closing down "cowboy" clinics, but experience shows that this is often a drawn-out process, and even when one business is closed down, it is all too easy for the same operator to start another similar business with a different name. Given that people's health and sometimes their lives will be at stake, this option does not seem to provide sufficient protection.

The RCN notes that the recent Health Select Committee report on *The Relationship Between Health and Social Services* recommended that the Government urgently consider a review of current Ombudsmen arrangements, as the existing legislation is considered out of date by both the Local Government Ombudsman and the Health Service Commissioner. The RCN supports the call to review the Ombudsman legislation, with a view to making the Ombudsmen services less fragmented and more reflective of the changing nature of health and social care provision. Such a review would seem particularly timely, given the proposed changes to the regulatory system overall. The RCN believes that patients who receive their care in the independent sector should also have the right to appeal to an Ombudsman, and that any review of the Ombudsman legislation should look at ways to provide a clear, effective and unbureaucratic service for all patients, whether their complaints are about NHS services, independent health care providers or social services, or span more than one sector. A review should also include an assessment of the resources needed to provide an effective and prompt service to patients, and the likely increase in demand. The RCN has recently begun working with the Consumers' Association to press for the remit of the Health Ombudsman to be extended to include independent sector patients.

Greater patient involvement

The RCN believes in principle that patients and users should be more involved in the regulation process, and would welcome the development of mechanisms and models which enabled this to happen. The RCN believes that this would lead to a greater understanding amongst regulators and providers of what patients actually want and need from their services, and where these needs are not being met. Patient involvement would have to be developed in such a way that it was not overly intrusive or demanding on patients' time and energy, but allowed patients to voice their needs, preferences and concerns.

Flexibility

Whilst strongly supporting a national regulatory system with national standards, the RCN believes it is important that inspection and registration officers should maintain some degree of flexibility in order to ensure that identified local issues can be properly addressed. There will always be some degree of "local" interpretation, and regulation and inspection officers need to be able to strike the right balance between being sensitive to local issues, and ensuring a consistent approach with reproducible standards and processes.

The current system is too inconsistent; the RCN has heard anecdotal evidence of very varying approaches between different inspection teams in different areas, with some inspections lasting around four to five hours, and others, of similar facilities with similar standards and outcomes, lasting up to two days. Some inspectors take a "checklist" approach, whilst others have developed training programmes and courses for care providers, in an attempt to raise standards. As discussed above, the RCN believes that a facilitative and developmental approach should be built into the role of the inspectorate, and that this will be the key to improving standards. In a multidisciplinary inspectorate, the knowledge, skills and competencies of inspectors could be much more effectively utilised, especially for specialist advice.

The RCN recommends that inspectors should be able to take account of quality assurance systems already in place when they are carrying out their inspecting and monitoring duties. The various quality assurance systems do not have a common ethos or guaranteed national standard and should not be seen as a substitute for the statutory process. However, the RCN believes that it would save time and be a cost-effective use of resources if membership of such schemes could be taken into account by inspection systems, in order to streamline the process and avoid needless duplication of effort.

5. FUNDING

The RCN notes that the *Modernising Social Services* White Paper proposes that the Commissions for Care Standards should be self-financing through fee income paid by regulated providers. The RCN supports this approach in principle, but would wish to see more detailed analysis of the overall costs involved, including the costs under a regulatory system that encompassed the acute independent sector. The RCN understands that research on the total costs of regulation is currently being carried out at the University of Kent.

In the absence of a detailed analysis, the RCN assumes that it would be more cost effective to have one regulatory system covering all care providers, than to have separate systems for different sectors, with the different infrastructures, administration and staffing that would be entailed. However we acknowledge that the costs of a national independent inspectorate, and the costs to that inspectorate, need to be considered in the widest terms. For example, health authorities currently have to pay for specialist advisers to assist in

29 April 1999]

[Continued

inspections where their own inspectors do not have the necessary specialist expertise (eg about lasers or forensic medicine). It is likely that a new independent inspectorate would still sometimes have to pay for advice from specialists within the NHS, and this would certainly be the case if the acute independent sector were included.

6. FREEDOM OF INFORMATION

Under the Open Reporting regulations that came into effect in England on 1 April 1998, and Wales on 1 January 1997, patients and those considering using a nursing home, hospital or clinic can request the inspection report for any registered home from a health authority. The RCN welcomed this move towards greater freedom of information, and believes it will mean patients are better informed, as well as increasing pressure on providers to maintain standards. The NHSE guidelines on open reporting state "the regulatory functions of Health Authorities provide an important protection for the public. They also have a major effect on the business of private and voluntary nursing home providers"¹⁰

The RCN believes that any future regulatory system for healthcare outside the NHS should maintain such open reporting requirements. Without access to inspection reports, patients would have less information on which to make decisions, or to pursue complaints about inadequate or poor standards. Providers themselves would have less information about whether their standards were adequate, and so find it harder to maintain and improve standards, even when willing to do so. The RCN sees no reason why the Commission for Care Standards should not be able to maintain a system of open reporting and freedom of information, whereby inspection reports were made available to the public.

7. CLINICAL GOVERNANCE, NATIONAL SERVICE FRAMEWORKS, THE NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE AND THE COMMISSION FOR HEALTH IMPROVEMENT

The Government have signalled their determination to address the question of quality and raising standards in the NHS, with the introduction of clinical governance and national service frameworks, and the establishment of the National Institute for Clinical Excellence and the Commission for Health Improvement. It is still extremely unclear how these various initiatives and bodies will interact with, and impact on those who provide healthcare outside the NHS. The Government have not indicated that there will be any interface with the independent sector, but given the significant numbers of NHS patients who receive their treatment in the independent sector, and the size of the independent sector overall, it seems that some kind of interaction will be inevitable. The RCN would like to see further clarification of that interface and interaction, and exploration of the implications for the regulatory body and the regulation system overall.

Both the NHS and the independent sector would benefit from initiatives to spread information about good practice and best practice, including sharing such information between the different sectors—ultimately, this should be to the benefit of patients wherever they are treated. Bodies such as the National Institute for Clinical Excellence need to be aware of clinical developments in the independent sector as well as the NHS. The RCN is aware of examples of innovative and good practice in nursing in the independent sector, and further information is given in Appendix 1.

8. NURSING AGENCIES

The RCN supports the proposals in *Modernising Social Services* to regulate organisations providing personal social care to people in their own homes (domiciliary care) and is glad to see that the Government "will also be considering further the regulation of nurses' agencies, particularly in view of the introduction of regulation for domiciliary care, to see what improvements can be made to the current system." The RCN believes that the Nurses Agencies Act 1957 is outdated and in need of urgent review and revision.

The RCN recommends that nursing and care agencies should all be monitored and registered by the new Commission for Care Standards rather than by trading standards officers (with input from social service inspectors) as nursing agencies are now. The RCN is currently liaising with the Department of Health and the Department of Trade and Industry on a way forward to update the Act. The RCN understands that the Employment Agencies Act 1973 is about to be revised and could be referred to in the Fairness at Work Bill.

¹⁵ Open Reporting in Nursing Home Inspections HSG (97), NHSE, 19 January 1997.

29 April 1999]

[Continued

9. CONCLUSION

The RCN believes that the current system for the inspection, monitoring and regulation of health care outside the NHS is outdated, and in need of significant reform. An effective regulation system is needed to provide protection for all patients receiving care across the full range of sectors and settings outside the NHS.

The RCN welcomes the proposals in the White Paper on *Modernising Social Services* for the regulation of long term care in nursing and residential homes, as well as children's homes, domiciliary social care, independent fostering agencies, residential family centres and boarding schools. However, the RCN is concerned by current uncertainties about the future regulation of the acute independent sector, and in particular the view that this sector might be deregulated or allowed to become self-regulating. The acute independent sector treats thousands of people every week, including significant numbers of NHS psychiatric patients who receive their care in specialist clinics, and the majority of the terminally ill receiving care in hospices. To deregulate the acute independent sector would be a disastrous abrogation of public responsibility, which would compromise basic standards and safe patient care. Every patient should have the right to minimum standards of quality, care and safety, irrespective of the sector in which they are treated.

The RCN believes that the Government now have an excellent opportunity to modernise the regulatory system overall, creating a new integrated system which can provide effective regulation for patients receiving care across the full range of sectors and settings, and will continue to press for the regulation of the acute independent sector to be brought within the remit of the Commissions for Care Standards.

The RCN has identified some examples of best nursing practice, as well as a number of questions and concerns relating to the regulation of specific kinds of care or providers of healthcare outside the NHS. These are detailed in Appendices 1 to 6 below. A diagram developed by the RCN's Forum for Nurses in Inspection and Registration, illustrating the process of regulation, is also attached.

January 1999

APPENDIX 1

INNOVATIVE NURSING PRACTICE AND BEST PRACTICE OUTSIDE THE NHS

The RCN is aware of many examples of innovative nursing practice and good and best practice taking place in nursing in the independent sector. Examples include:

- comprehensive training and educational programmes, including National Board accreditation, NVQ/SVQ training, and Enrolled Nurse Conversion programmes
- development of clinical nurse specialist roles
- collaboration with NHS trusts to develop clinical services
- return-to-nursing-practice programmes
- clinical audit and risk management programmes
- development of Integrated Care Pathways
- clinical placements for nurse students offered to local education consortia, with an appropriate educational audit incorporated
- development of clinical audit in conjunction with the hospitals' Medical Advisory Committees
- creation of multi-disciplinary quality improvement teams, led by nurses
- development of nurse-led health screening programmes
- secondment of nursing staff into higher education eg to gain diplomas, BScs, MScs leading to advanced nurse practitioner awards
- establishment of evidence-based standards, guidelines and protocols.

Practice development has been defined within the independent sector as being concerned with improving the quality of patient care, and encouraging nursing staff to develop and appraise professional and innovative practices.

APPENDIX 2

REGULATION OF MENTAL HEALTH CARE OUTSIDE THE NHS

Some 20 per cent of the NHS's mental health patients are actually treated in the independent sector, many in highly specialised hospitals and clinics. The largest independent sector provider of specialist treatment for people with mental health needs has approximately 600 beds. The types of mental health problems for which patients may receive treatment in the independent sector include:

29 April 1999]

[Continued

Additions	Post traumatic stress disorders
Alcohol/drug abuse	Psychogeriatric disorders
Adolescent psychiatry	Psychiatry
Anxiety problems	Psychological symptoms resulting from
Bereavement and loss	physical disease
Chronic fatigue syndrome	Relationship difficulties
Eating disorders	Sexual dysfunction
Family problems	Somatoform/sleeping disorders
Marital problems	Stress disorders
Obsessive compulsive disorders	Transcultural psychiatry
Occupational Mental Health	Workplace related emotional problems
Phobias	
Post-natal depression (mother and baby care)	

The RCN has identified the following concerns which should be addressed by any future regulatory system covering mental health care provision outside the NHS:

- Safety and standards of the facility are paramount, and should be monitored at the point of inspection and registration.
- The system must ensure that the advice and guidance given by the Mental Health Act Commissioners is monitored and followed.
- As the Mental Health Act Commissioners only deal with detained patients, mechanisms are needed to ensure that the interests of patients not detained under the Mental Health Act are also looked after.
- Proprietors developing mental health premises may have little knowledge or understanding of the Mental Health Act 1983 eg the role of Hospital Managers, Approved Social Workers etc.
- All paperwork relating to the Mental Health Act 1983 must be comprehensively and accurately completed; in many cases Mental Health Act Commissioners have reported errors during their visits.
- The inspectorate should scrutinise mental health forms, because of the sometimes infrequent visits by the Commissioners.
- The medical and nursing staffing of the units are currently strictly monitored by health authorities due to the shortage of psychiatrists, mental health nurses and occupational therapists. This monitoring should continue under any future system, as otherwise units could fall well below safe levels of staffing.
- At present, health authorities are more of a local point for complaints (including by those detained under the Mental Health Act) than the Commissioners, and may be able to visit quicker than the Commissioners. A future inspectorate should be at least as responsive to patients' complaints.

APPENDIX 3

REGULATION OF DETOXIFICATION UNITS OUTSIDE THE NHS

The RCN has identified the following concerns which should be addressed by any future regulatory system covering detoxification provision outside the NHS:

- At present, the health authority works in conjunction with pharmacists to monitor closely the dosage and combination of drugs used for the purposes of detoxification. Drugs which are currently not licensed for a particular purpose may be used experimentally for detoxification. Any future regulation system should continue this close monitoring role in relation to drugs.
- It is essential that admission criteria for different detoxification units are clear. People with complex and multiple needs (eg complicated alcohol and multiple-drug-use) may not be appropriate admissions for some kind of units. Units should not be allowed to accept anyone, irrespective of their ability to treat their particular needs.
- It is becoming increasingly popular to undertake rapid detoxification procedures ie 48 hours heroin detoxification. This is potentially dangerous and needs very careful monitoring by appropriately qualified and experienced staff.
- Medical cover and input into these types of units can sometimes be sparse and this needs close monitoring by any future inspectorate.

*29 April 1999]**[Continued]*

- Admission and discharge procedures can sometimes not be properly followed, particularly when patients are admitted across different local authorities. The health authority can recommend that policies and procedures with regard to these issues are in place, and a future inspectorate may also have to make such recommendations.

APPENDIX 4

REGULATION OF FORENSIC PSYCHIATRY AND MEDIUM SECURE UNITS OUTSIDE THE NHS

Fifty-five per cent of all forensic psychiatry is carried out in the independent sector, with one of the major providers being Partnerships in Care. The three largest independent forensic psychiatric hospitals are Stockton Hall, Cheshire, Kneesworth House, Hertfordshire, and St. Andrews, Northampton. The NHS Executive has a Forensic Forum which is accessible to the independent sector providers.

The RCN would like to use the procedures at Stockton Hall, which is run by Partnership in Care, to illustrate good practice.

Assessment criteria are key to ensuring that the facility is the correct one for the individual patient. The specific criteria used at Stockton Hall are:

- the patient's willingness to have treatment
- the ability to provide a service to meet the patient's needs
- the referrer being able to fund treatment to meet the patient's needs
- the acceptance of the clinical team that they can meet the patient's needs
- the impact that the patient may have on other patients in the care area

The assessment process is part of an audit trail, which addresses the quality of assessment documentation, patient involvement, and clinical team involvement. Comprehensive assessment documents include the patient's levels of anxiety, depression, suicidal tendencies, mania, hallucinations, delusions, flattened affect, incongruity, overactivity and pressure of speech, psychomotor retardation, incoherence or irrelevance, poverty of speech, abnormal movement of postures, co-operation, and risk analysis guide.

A care programme—Approach to Care—is used, embracing four key elements:

- individuals identified as requiring psychiatric services should automatically have their health, social and other needs assessed
- a series of care plans will be developed to address the areas at regular intervals of identified need/development
- a Key Worker will be appointed to monitor the implementation of the care plan, and liaise closely with the patient and other associated staff
- the care plan will be reviewed regularly and updated when required

An independent complaints mechanism has been established by Partnership in Care. The level of complaints is described as "high", which is understandable in view of the types of patients being treated. Further information about the complaints mechanism can be made available to the Health Select Committee should they be required.

Partnerships in Care describe themselves as both performing a self-regulatory function, but also understanding the importance of external examination.

APPENDIX 5

REGULATION OF CHILDREN'S HEALTH CARE OUTSIDE THE NHS

The RCN has identified the following concerns which should be addressed by any future regulatory system covering children's health care provision outside the NHS:

The RCN has raised concerns over a number of years about the standards of care provided for children in independent sector hospitals. In September 1996 the RCN and the Royal College of Paediatrics and Child Health (RCPCH) jointly wrote to the Department of Health requesting clarification and confirmation that DoH guidance relating to the care of children in hospital as documented in "Welfare of Children and Young People in Hospital" (1991) and "NHS Patient's Charter: Services for Children and Young People" applied to children who were private patients in both NHS and the independent sector. This request was precipitated by the increasing number of incidents of inappropriate care, particularly of children receiving surgery, brought to the Colleges' attention. The majority of children are admitted for minor surgery, but concerns also related to children with a range of acute and chronic clinical conditions under the care of adult physicians and general, orthopaedic, plastic, gastro-intestinal and neuro-surgeons. Specific concerns are:

*29 April 1999]**[Continued*

- The age range of the children had changed, so that units which previously did not admit children under eight years, are now admitting toddlers and infants even if they lack the necessary equipment, facilities and experienced staff.
- Increasing numbers of children receiving care as private patients in a wide variety of institutions, but rarely more than one or two children in any unit at a time.
- Failure to provide equipment appropriate to the size and age of child, including resuscitation equipment.
- Medical and nursing staff who have not received specific education or training, or have any specific interest in children's health, and failure to provide "in service" training relating to children, even for resuscitation. It appeared that it was not common practice to have staff "police checked" for suitability for working with children.
- Failure to provide policies or protocols specific to the needs of children.
- Prescription of drugs and routes of administration, particularly for young children, with no paediatric pharmacy back up.
- Poor recognition and management of pain, as the staff are not skilled in identifying or treating children's pain, with some doctors still believing that young children do not feel pain.
- Failure to provide appropriate environment and facilities eg bed rails designed for children rather than adults.
- Contact with paediatric medical and nursing staff is not encouraged and in some instances forbidden even when children are private patients in an NHS hospital because: (a) the consultant under whose care the child has been admitted believes advice from staff knowledgeable about children is not required or (b) requests, even for nursing advice, are required to be in writing, and then charged to the patient's bill and the consultant does not wish the parents to know that advice was sought.
- Nurses who express their concerns over standards of care being told if they are not happy with the practices of their employer they should seek alternative employment.

The RCN acknowledges that many children receive a good standard of care in the independent sector. However, all children and their parents should be entitled to just as high a standard of care as any adult. The majority of issues identified by the RCN are already meant to be covered by the existing monitoring system, but clearly in some instances they are not being adequately addressed. Any new inspectorate and regulatory system should specifically address the needs of children, in terms of its staff training and expertise, and its standards, guidelines, protocols, etc.

In February 1997, the Department of Health replied to the RCN and RCPCH "The position of the DoH on this is as follows. Standards for the care of children in private facilities, whether they be in a NHS hospital or a private hospital are not the concern of the Department". After the general election, the Colleges again wrote to the DoH stating that they felt strongly that the reply was an abrogation of responsibility and requesting that the issue be raised with the new government. In January 1998 a response was received stating that "Children receiving private care in NHS hospitals should be provided with the same standards applicable to any other child." However this information has not been sent to NHS Managers and in view of the DoH's previous statement, it is not surprising that managers and medical staff, particularly those whose work mainly comprises adult patients, appear unaware of this change. The DoH letter also states "The responsibility for ensuring that appropriate standards apply to children in the private sector must lie with the parents and those purchasing and providing the services".

29 April 1999]

[Continued

There are a growing number of child psychiatric units, with the largest at Ticehurst House Hospital. East Sussex and Rhodes Farm, London. The numbers of children admitted to Ticehurst House in 1998 are provided for information:

<i>Age</i>	<i>Numbers (male)</i>	<i>Numbers (female)</i>	<i>Total</i>
0-9	2	6	8
10	0	0	0
11	3	1	4
12	4	9	13
13	7	5	12
14	5	12	17
15	7	13	20
16	4	16	20
Total	32	62	94

The RCN's Paediatric Nurse Managers Forum recently circulated 241 questionnaires to independent sector units looking at where the children are nursed, the availability of paediatric emergency procedures and nurse staffing. Results are being collated, and can be presented to the Health Select Committee if requested.

Finally, the RCN acknowledges that there are certainly some areas of very good practice in the care of children in the independent sector, and some of the major groups have corporate policies on children's issues. The Health Quality Service at the Kings Fund have a specific document relating to children being cared for in the independent sector which is used in the audit process. An excellent example has been submitted by the Benenden Hospital and could be used to demonstrate good practice.

APPENDIX 6

REGULATION OF CARDIAC RESUSCITATION PROVISION OUTSIDE THE NHS

The RCN has identified the following concerns which should be addressed by any future regulatory system covering cardiac resuscitation provision outside the NHS:

Cardiac resuscitation has been a concern within the independent sector due to the degree of medical staff cover. Unlike NHS hospitals, some independent sector facilities may not have suitably qualified medical staff on the premises at all times. Cardiopulmonary arrest is one of the commonest medical emergencies that might occur within a hospital or clinic, and prospects for survival diminish with each minute that passes from the onset of the arrest to the receipt of the necessary treatment. It is imperative that resuscitation can be dealt with wherever vulnerable patients are cared for, and the future regulation system should address this as a fundamental requirement.

Advanced Life Support (ALS or ACLS) involves the use of advanced equipment for which advanced skills, techniques and knowledge are required. Widespread training of medical, nursing and paramedical staff in basic life support, and in selected advanced skills, develops the competencies required in the management and conduct of cardio-pulmonary resuscitation.

Most patients in the independent sector do not have a particularly high risk of cardiac arrest, but cardiac arrests will still happen and any health care facility should be prepared for the event. A medical practitioner should be available to participate in any CPR attempt, but it would be more practical for the arrest to be led by permanent nursing staff who will have the necessary training and will be more familiar with the hospital layout and equipment than a Resident Medical Officer (RMO). All those involved, including the RMO, should have regular ongoing training in basic life support to maintain their skills, and there should be suitable numbers of individuals with an advanced certificate to ensure someone is available at all times. Clear guidelines are issued by the European Resuscitation Council can be easily audited by inspectors.

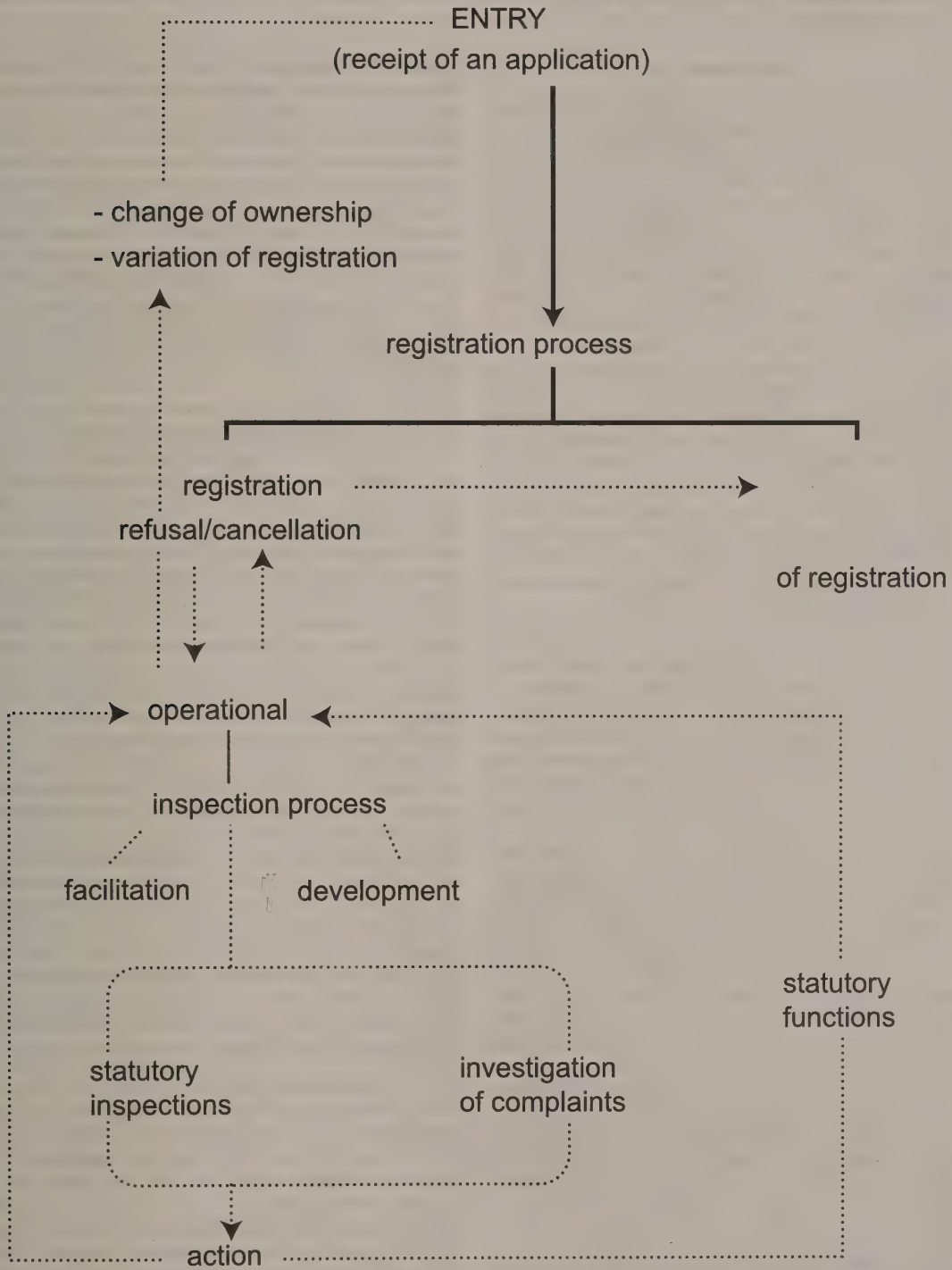
The availability of up-to-date equipment in the hospital is also crucial, and the RCN understands that, at present, some independent sector facilities do not have the necessary equipment, or their equipment is obsolete and unable to deliver the correct amount of energy to treat the cardiac arrest. Again this is easily audited and it falls within nursing accountability to ensure that any equipment required is capable of performing the task required and is regularly maintained.

Finally, it is important for providers to audit all resuscitation attempts, reflect on practice and make any changes to practice that have been identified.

29 April 1999]

[Continued

THE PROCESS OF REGULATION



29 April 1999]

[Continued

Examination of Witnesses

MR DEREK MACHIN, Chairman, the Private Practice Committee, British Medical Association, Ms SALLY TABER, Independent Sector Adviser and Ms PIPPA GOUGH, Director of Policy, Royal College of Nursing were examined.

Chairman

787. Colleagues, can we begin, and can I welcome our witnesses for the first part of this morning's session. Could I ask our witnesses briefly to introduce themselves to the Committee. Mr Machin, would you like to begin?

(Mr Machin) My name is Derek Machin. I am Chairman of the BMA Private Practice Committee. I am also Deputy Chairman of the BMA Central Consultants and Specialists Committee. Professionally, I work as a consultant urologist at University Hospital, Aintree, in Liverpool.

(Ms Taber) My name is Sally Taber. I work for the Royal College of Nursing, mainly looking after the independent sector. Prior to working at the Royal College of Nursing, four years ago, I worked in the independent sector at Director of Nursing level for ten years, and, before that, 23 years in the NHS.

(Ms Gough) My name is Pippa Gough. I am Director of Policy at the Royal College of Nursing and Head of the RCN's Policy Unit, and prior to working with the RCN I worked with the nurses' statutory regulatory body, the UKCC.

788. Can I begin by thanking both of your organisations for your very helpful written evidence, which has been very useful for the Committee in respect of this inquiry. Could I ask you, Mr Machin, one or two questions, to start with. Over and above what you have given us in a written form, would you just describe to the Committee the specific problems that your organisation sees currently with health care within the private sector?

(Mr Machin) By and large, we do not see that there are major problems in what we might describe as the mainstream part of the private sector, and, by that, we mean practice associated with private hospitals and done by specialist consultant doctors. On the whole, we feel that, although the regulatory mechanisms are not terribly transparent, in practice, they will usually work. Our anxieties are much more around the other areas of independent practice, and, in particular, around practitioners who seem to become involved with areas such as slimming clinics, who suddenly metamorphose into experts in impotence; the commercial activities around plastic surgery, where the impetus seems to be commercial, rather than offering a service to people who really need it. So that is how I would divide the concerns that the Association has, at the moment.

789. Could I ask a specific question? You suggest, in your evidence, that the responsibilities in terms of regulation of the Medical Advisory Committee at an independent hospital should be enhanced; one of the issues that we have been exploring is the possible conflict of interest between people who may serve on that Committee and also may be practising and having a business interest in the success of that particular independent hospital. One of the areas that we have explored throughout this inquiry, in a sense, and certainly last week, was the conflict that

does arise, which is picked up by the RCN's evidence, I think, between professional accountability and business accountability. Do you not see some difficulties possibly arising in respect of that conflict with the model that you are proposing to enhance?

(Mr Machin) I would hope not. I think that the same arguments apply in the Health Service, quite frankly, that there can be conflicts of interest between professional activities and the way in which NHS hospitals are financed, and one sees this from time to time, it is not quite as obvious, but it is there. I think that anybody who had a financial interest in the hospital should debar themselves from taking part in the process, frankly.

790. But, surely, if they work in that hospital then they have got a financial interest in that?

(Mr Machin) I would not agree with that. I think that there is a difference between having an ownership of a hospital, and therefore participating in the financial success, or otherwise, of that hospital, and merely working there. Most of us can choose to move to another private hospital, if we wish, and private hospitals do fail, and one has recently failed up on Merseyside. So I think there is a difference, frankly. There are other conflicts of interest, one has to say, which worry me at least as much, because not everybody behaves in the way in which we would hope they would behave, and much the biggest conflict of interest is the rivalry, if you like, between practitioners. And that is something one has to be very aware of, both in the Health Service and in the private sector, with regard to suspensions and criticisms, that not all of the criticisms, not all of the suspensions, arise out of a careful assessment of the situation; just occasionally, there is a certain amount of malice that comes into it. So it is a multifactorial problem. But, I think, if people exercise the proper level of probity and declare any interest they have then that is the minimum one would expect. But, as I said, if somebody really had a deep-seated, vested interest, and certainly a financial interest, then I think they ought to debar themselves from the process.

791. I am trying to make the distinctions that you imply between where people will and will not have some financial interest directly or indirectly, and I want to explore the difference between yourself, or your organisation, and the RCN, who take a different view on this, and other organisations take a different view from the BMA. Because what you put forward is quite clear, and a model that you believe will work; other organisations have raised serious questions about it, for the reasons that I have suggested. You make the point about the model working in the NHS, but are there not some distinctions between the way the NHS operates and the way the private sector operates, in that, surely, within the private sector, and this is the area we got into in our session last week, there is, to some extent, a vested interest, a pecuniary interest, in a surgical intervention? We went to an establishment yesterday whereby people are given a price list of various

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Chairman Cont]

interventions, and you can go in and see a GP and then discuss possible interventions that you may need. There is very clear evidence that, in the States, where we have a market system, there is far more surgical intervention than there would be with similar complaints in this country. So what I am saying to you is, surely, with the model that you have got, there is an in-built incentive to perhaps turn a blind eye, perhaps, to practices whereby interventions are taking place, in the pecuniary interest of that hospital, that are not necessarily appropriate; do you understand the point I am making?

(Mr Machin) I do, indeed, yes, absolutely. I am not sure that the MAC necessarily is the vehicle which would actually pick that up.

792. So where would it be picked up? Because the point I am making is, that is your model, that you are offering us; now I accept you will say possibly the GMC may come in here, but the MAC will have some role, initially, at least, presumably, where there may be a complaint, a problem, an issue, raised by a patient, or a family member, or whatever?

(Mr Machin) What the MAC was looking at, I would say, was standards of practice, insofar as the quality of the work that was carried out was appropriate; now what you are asking is the decision-making about whether that work is appropriate in the first place. Now the BMA view is absolutely clear, that we should be offering a similar service in the private sector to that we would have offered in the Health Service; and certainly that is my own practice, that I would not offer somebody an operation in the private sector that I would not offer them in the Health Service, and that is the right attitude. It has to be said, even taking that sort of view, that there will tend to be more surgery done in the private sector, because people will express a desire to have it done; having explained to them one's view that this is an optional operation, that they do not have to have it, in the private sector, maybe more people will tend to go for it than in the Health Service. There are other differences between private patients and Health Service patients; private patients tend to be younger, they tend to be better informed, they tend to be, in general, healthier, whereas, in the Health Service, one is looking at people who are older and sicker, by and large. So there are other aspects one has to look at when bearing in mind that there will be marginal variations. If there are huge variations then I think that does bring somebody's practice open to question, and this, I think, is where the General Medical Council comes in, and the responsibility of all doctors; because if doctors, within a private hospital, are aware that a practitioner is behaving totally differently in his private practice compared with his Health Service practice then, in my view, it is the duty of those doctors to draw this to the attention of the MAC Chairman. So I think that the system will work in that situation, albeit that was not particularly the reason why we suggested that particular model, but it would be one of the things which ought to be picked up if there was quite clearly aberrant behaviour by a consultant.

793. One of the areas that we touched on last week, in particular, to do with the cosmetic surgery side, was the way in which people are enticed to go for

operations, treatments, on occasionally a very dubious pretext, and we were, I think, all of us, worried that the process whereby people initially are met in certain private clinics by people who are not medically qualified, effectively sales persons, and then eventually see a doctor, raises questions about how there is a check on where people get in, in the first place, and the appropriateness of the intervention. I still do not understand your model, if we do not have that gatekeeper there, which clearly is not existing in a number of organisations. I take your point about the distinctions that you see in the private sector, and we fully understand that point, but I do not see how your model of the MAC within the private hospital will prevent some of the problems that we have seen occurring, whereby there is not a check on why people end up having unnecessary operations. I am not clear quite where that check would be?

(Mr Machin) I would have said that part of the problem with the private clinics offering plastic surgical services is that they advertise directly to the public. Now the Association is absolutely clear that the best interests of patients are served by going through their general practitioner; the general practitioner/gatekeeper role has served not only the Health Service well but it has also served patients well. So if patients choose to circumvent that process then they immediately place themselves at risk.

794. But they may not know that, of course; and who should tell them?

(Mr Machin) They may not know it, but part of the role of this Committee, I suspect, is to raise the profile of publicity around these sorts of issues. But that actually brings up another whole issue which is of great concern to us, which is the question of title, because people who go to private cosmetic surgical clinics may see somebody who is described as a consultant, but that is a sales consultant rather than a medical consultant. And we are very concerned that, in general, and this applies to a greater extent in the private sector, although confusion is now being generated in the Health Service as well over titles, and there is no protection of title, and unless an individual purports to be registered as a medical practitioner then they can do more or less what they want to the population. So we have this very odd situation in the UK where the population is inherently at risk, that anybody can operate on any person in the UK, but I, as a qualified surgeon, cannot operate on an animal without a veterinary surgeon present. So we have a very odd situation, which actually is the root cause, I believe, of the problem; and if that is not sorted out then it is going to get worse.

795. You have made some very valid references to the role of general practitioners, and I was interested to read in your evidence the concern the BMA expresses about the advent of walk-in services within the private sector. We, as a Committee, visited one example in London yesterday, and I think that visit raised a number of questions about the lack of regulation of that sector, which I think was an area that the people we met themselves were concerned about, but also the relationship between what they were doing and the individual patient's own NHS GP. I would be interested in you expanding briefly on

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Chairman Cont]

your concerns about walk-in services, and what the BMA believe should happen with regard to those services that obviously are separate from the broader hospital side of the private sector?

(Mr Machin) This, of course, has now been complicated, because the Government have now announced an initiative to have rather more of these walk-in services and nurse-led services. And, interestingly, and I found this out only last week, there have been two pilot studies going on in Liverpool for some time; these have been brought in with the co-operation of the local general practitioners, and the Secretary of the Liverpool local Medical Committee said that the local GPs are very happy with them, that they had been set up properly, there was proper communication and they were working well. So I think that is the essence of it. They are not, of themselves, necessarily, wrong, they are not necessarily dangerous, but there has to be proper communication and there has to be some agreement as to where the boundaries stop. We also have problems with people who go off to screening clinics, and this is another area which can be of great difficulty, where a patient goes along and has screening and the results are then sent back to the GP, and the GP is landed with the problem of explaining tests which he would not actually have had done himself, and screening for prostate cancer being a classical example, where the patient may or may not have had a full explanation of the implications of the test before it was done, but it very often falls to the GP to sort out the problem, in the longer term. And my view is that if you offer somebody a service then you actually have to be prepared to follow it through, and you have to be prepared to deal with the consequences of what you have done, albeit it may be just a test result. But I think you really do have then to be prepared to spend the time to explain to the patient, both before you do it and when the results have come through, what it all means for that patient, and not just expect that the patient's GP will then pick up something which they had no earlier responsibility for.

796. It was put to us that a number of patients do not want their own GPs to be made aware of the treatments they are receiving from these walk-in centres, for various reasons. One of the areas that we touched upon was the suggestion that the clinic we went to will very shortly be able to prescribe Viagra, and I made the point that this is not an area where the individual's own GP should be made aware of these prescriptions, giving the example of a situation I could envisage, whereby the NHS GP is perhaps treating the partner in that relationship, and it would seem to me to be fairly important that they were made aware of the prescription by the walk-in clinic. What are your views on that general area of the relationship in those circumstances, and what do you feel,—clearly, the Committee will be wanting to look at recommendations that you make,—should happen to address the clear lack of regulation of this area, but also what do we do about the way in which, presumably, patients are free to say to such a clinic "Don't tell my own NHS GP"?

(Mr Machin) I am very uncomfortable with that whole concept. The concept of secrecy between doctors of medicine is a bad one, and I could wax

lyrical on the subject of HIV and Aids and the fact that it came to light in genito-urinary clinics and what the results of that have been; but, by and large, it has not been a happy experience. Viagra, again, is my own specialty and is an area I am intensely interested in, and it raises very serious questions, because my view, and the view of the British Association of Urological Surgeons, has always been that Viagra is a classical drug to be used by general practitioners, who actually know about the history of the patient, which somebody else may not. And, to give you a sort of personal example of this, I saw a patient privately who had been previously referred to me in the Health Service, but at the time I saw him I did not have his notes, and I went through the full history and examination, and so on, asking very specific and detailed questions about any question of cardiac problems and the drugs he was on, to which I received negative answers. I therefore prescribed Viagra. I got back to the hospital a couple of hours later, by which time my secretary had produced the notes; in the notes, this patient had actually been on the coronary care unit two months earlier, when he was referred to us a year or so earlier had been on a drug which is on the prohibited list, which I had actually asked him about, Isosorbide mononitrate, and he had been on that right throughout the whole procedure. So this demonstrates very clearly that you may ask the question, you may not get the answer, and so involving the GP is so important to the protection of the patient. And I feel that unless the practitioner who sees that patient in a walk-in clinic is prepared to continue seeing that patient and to continue taking responsibility, and the patient is prepared to continue seeing that doctor, then that individual should not prescribe for the patient if the patient says "You cannot tell my GP".

797. So, presumably, you are arguing for that registration to be transferred to the walk-in practice from the family GP?

(Mr Machin) That would be one argument. What I am talking about is a specific situation where the patient says to the private GP "You cannot tell my NHS GP." I do not think that is a tenable position for the private practitioner, unless the patient then decides that he is going to see that person from then on. I think it is extremely dangerous to have two people looking after the same patient, possibly for the same condition, I think that is absolutely asking for disasters.

Dr Stoaite

798. I would like to bring you back briefly to mainstream private practice. I understand, right at the beginning, that you said that you saw a clear distinction between mainstream private practice and some of the more fringe areas, but I would like to bring you back to mainstream private practice. You have given some reasons why you think that people are more likely to receive a surgical intervention in the private sector, and you mentioned that patients might be younger and fitter, but, of course, in the NHS, there are plenty of young and fit patients as well, and yet they are far less likely, and there is plenty of evidence to show this, to receive things like grommets, hysterectomies, and a number of other

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Dr Stoate Cont]

things, which I do not think you could reasonably put down simply to the reasons you gave. Could you expand on that point just a bit more?

(Mr Machin) Yes. There is another factor, of course, which is, if there are pressures in the private sector, financial inducements, if you like, to operate, then there are equal pressures in the Health Service not to put people on waiting lists; so there is a nice balance here between the two sectors, in which you have opposite imperatives applying. So, often, the cases we are talking about are very much cases where, yes, you could have it done and you could choose not to, and it is very much up to, it should be entirely up to, the patient, in that situation, having been counselled by the doctor, whether they decide to go ahead with the procedure. The implication is, if people turn up to a surgeon with a problem which has a surgical solution, that they are going with a view to having surgery, that is the implication; it should not be an assumption made by the surgeon that that therefore naturally follows. I do not feel necessarily that the implication is that, because there is a percentage done in the private sector, this is always as a result of the venal view of the surgeon to the treatment of the patient.

799. Certainly, there is plenty of evidence in America that would suggest that the amount of surgery carried out in a particular area is directly proportional to the number of surgeons, and nothing whatever to do with clinical need. But, to get back to this; nevertheless, from what you are saying, there is clearly a difference of practice, clearly, people in the private sector, the same surgeon, must, by implication, by definition, be doing more surgery, and, therefore, not the same clinical practice. Because something else you said was that where you saw a surgeon offer a different service, or a different type of clinical practice, you think that is a problem, but there is different practice going on, clearly?

(Mr Machin) I am not sure that I did say that; if I did, I did not mean to express it in that way. What I am talking about is, around the margins, I would not expect there to be a huge difference. If, for instance, somebody in the Health Service did hysterectomies on 10 per cent of women who came along with heavy bleeding, I would not expect them, in the private sector, to operate on 90 per cent of women with heavy bleeding. Now if the difference was 10 per cent and 12 per cent then I would not be particularly concerned about it, but if there were huge differences then I would be concerned about it.

800. I can certainly find examples where it is a much wider gap than just a couple of per cent. But the point I want to make is that you mentioned that if there are significant differences, or significant worries, they should be reported to the MAC Chair. Now my next question is, surely, is not the MAC Chair in a difficult position, in terms of conflict of interest, because he, or she, will be working for the same private hospital? There will also be, again, what you mentioned, which was this possibility of jealousy, where a consultant might be seen to be in direct competition with another consultant; does not that raise all sorts of conflicts of interest?

(Mr Machin) To answer your first question, we are not working for the private hospital, I would like to make that absolutely clear, and this is one of the

really important issues that has come up over the last few years with regard to managed care in the private sector, with insurers producing networks, insurance companies producing consultant partnerships, and so on. These are the sorts of relationships we do not want to see developing, because it is most important that the practitioner is truly independent and, therefore, gives truly independent advice, not biased by any relationship that may exist between him and the insurer, or him and the private hospital. So that really is the first issue. The question of jealousy, and so on, yes, it is a potential problem, and one which I highlighted, which means that the Chairman of the MAC has got to be aware of it and has got to be very careful in assessing the nature of the complaint. The other situation where this sort of complaint could arise could be from the private insurers, who become very aware if somebody is several standard deviations away from the norm, and that, again, could give rise to complaints, which could be dealt with, at least initially, through the MAC mechanism. If that mechanism were defective and there was clearly a problem in the view of the insurers then the GMC is there, as the final arbiter, if you like, of practice.

801. Finally then, do you really believe still then that the MAC system is the best way of sorting out these types of clinical differences in the private sector?

(Mr Machin) I think it is the only practical way of dealing with it; it is analogous to what we are doing in the Health Service. There is no reason why it should not work. I think, one of the problems that the Committee may have is realising that there has been a considerable change of attitude within the profession, certainly over the last five years, but over the last ten years, the profession is much less protective of its own. The profession recognises that it has a duty to patients, and, what is more, that duty has been absolutely underlined by the General Medical Council, which has made it abundantly clear that, should you ignore poor practice on the part of a colleague, your registration is under threat. And this really came out with the Doctor (Irani ?) case, a few years ago, when, was it, the Clinical Director, with the Chairman of the Anaesthetic Division, who had failed to act on complaints, was, I think, admonished by the GMC, but it was made very clear that a future case would be dealt with much more harshly and that the person's registration might very well be forfeited. So I think that most people understand the problem and understand that their registration is under threat. The paper which the Association has produced really is to formalise what already exists and, we feel, to draw attention to MACs and the membership of the MACs that actually they are in a vulnerable position and they really do have to discharge the function in a proper, professional manner.

Audrey Wise

802. Exploring the question of relationships with insurers a little further, and building on the answer that you have just given to my colleague, there are two things in my mind. One is that, yesterday, in informal discussion, it was put to me, quite strongly,

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Audrey Wise Cont]

by a consultant, who works in the private sector as well, his anxiety about relationships with insurers, and particularly the thing that you just touched on there, the development of different kinds of relationships and so-called partnerships, which will introduce other conflicts of interest. It was suggested to me, for example, that if a doctor is going to lose a bonus, or what is effectively a bonus, offered by an insurer then this may influence his decision-making, or it is expected, it is intended, really, to influence his decision-making; and would you like to say what you think should be done about this?

(Mr Machin) The main problem that you allude to is the BUPA Consultant Partnership, and the Association has opposed that, right from the outset, for the very reasons that you have described. We do not think it is appropriate that fee-charging consultants get a bonus from an insurance company at the end of the year for complying with certain restrictions on their practice. We have issued advice to the profession about that, drawing attention to the potential problems, with the General Medical Council, because we do believe that patients have to be made aware of that, but we do not believe, even if the patient is aware, that it totally protects the practitioner. One of the main problem areas we see is the question of the choice of hospital, and so often the choice of hospital is a grey area; a lot of patients are not totally fit, and whether you treat that patient in a hospital which has an ITU, an HTU, resident anaesthetists, and so on, or whether you treat them in the private hospital, which is perfectly adequate but will not cope with ITU patients, and so on, who would have to be transferred, we are making these judgements all the time. When I make that judgement, I do not want to feel that anybody can point the finger and say I made the judgement as a result of a financial inducement, I would not be comfortable with that arrangement, and most doctors are not; some, however, have joined the Partnership and leave themselves vulnerable to the charge that their decision-making was influenced by financial implications. I actually think enough of the profession to think that is not the case, but they are very vulnerable to that charge.

803. So what do you think should be done about this, whose job should it be to prevent the existence of such an arrangement; if it did not exist then everybody's problems are solved, on this particular point: whose job?

(Mr Machin) This is a very interesting area. We have talked with BUPA, over the last two years and more, about this, we have expressed the strongest opposition, we have got into legal problems with BUPA over our opposition to this, and so we have done as much as we can do with regard to negotiating it away. The fact that they are so keen to maintain it clearly indicates that there is a commercial value to this arrangement. They would argue that the commercial value is because they can assure patients that they will receive a full refund of fees; that is true. On the other hand, we also know that somewhere round about 95 per cent of consultants dealing with BUPA-insured patients charge within the BUPA schedule of fees, despite the fact that they have not increased the reimbursement under that schedule since 1992. So the evidence that there is a major

problem is small, with regard to shortfalls of fees, and the evidence that this is a commercially-driven Partnership is, I think, very strong. So, there is no mechanism that I am aware of which would prevent that Partnership continuing at present.

804. So should there be a mechanism, and, if so, whose job should it be to introduce it and enforce it?

(Mr Machin) It falls into all sorts of areas. It could fall to the Office of Fair Trading, for instance, it could be considered to be anti-competitive, because associated with this is the restriction on hospital, the use of hospital, so there is undoubtedly an anti-competitive element to it; but the Office of Fair Trading at the moment are having an informal inquiry, and we would have to see what the results of that informal inquiry were, and whether they actually picked up specifically on the Partnership. And the other arrangements that other insurers have, including BUPA, of networks, so that the access to hospitals is restricted, sometimes, allegedly, on quality criteria, but usually on the basis that the insurers want to restrict the number of hospitals with which they deal. And some of them are explicit in the view that they want to actually knock some of the private hospitals out of the market, they want to reduce the number of beds, and one of the ways of reducing the number of beds is to actually not allow certain hospitals into their network. So there is a great anti-competitive area here, which one hopes that the Office of Fair Trading will look at very seriously.

805. So that is suggesting that the solution lies in a business type approach, and not through professional channels; you do not, for instance, think the GMC should have a role?

(Mr Machin) We have involved the General Medical Council in this, and the General Medical Council have given a view with regard to the professional problems which involvement in a relationship with an insurer, such as the BUPA Partnership, do create; but that is as far as it can go. They will act only regarding a complaint about an individual practitioner, they cannot act as a sort of class action for the whole profession.

806. Do you think they should be able to?

(Mr Machin) I do not think they should, quite honestly, I do not think that is their role. I think their role is to regulate the activities of individual practitioners, and I do not think they should really be concerned about something such as the BUPA Partnership affecting the whole of the profession.

807. That is rather odd, because that suggests that it is a picking up of casualties after problems have happened rather than any sort of preventive role and protective role, both of the profession and patients; it seems a very restrictive view about professional responsibility and regulation?

(Mr Machin) Yes, in a way, it is. I think that the GMC acts, effectively, as a court of law, and it has to have evidence of poor practice in order to act against an individual. What you are proposing would be that they had the ability to act against an insurer, and that is outwith their remit, at the moment.

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Audrey Wise Cont]

808. No; there is the other aspect. There are two bodies in partnership, are there not, two sides to it, and the GMC does have responsibility in relation to the medical side of it, they would not be acting against the insurer, they would be acting in relation to what doctors could or could not do?

(*Mr Machin*) That is right. They have set down the rules and then individuals will be judged against those rules; and if a doctor is a member of the Partnership and the GMC find that, as a result of his membership, he has acted in a way which has resulted in harm to a patient then that doctor will then have the full force of the GMC brought down on him. I have to say, much as I would like to find a GMC mechanism which would actually stop doctors taking part in the Partnership, I really do not see a mechanism which could be instituted which would assume that doctors who were members of the Partnership were acting unprofessionally; that is the implication of your question. And I do not think the GMC would be happy about something which was a sort of blanket rule, saying that, if you are in this sort of relationship, of necessity, you are acting unprofessionally. It is something we would have to look at very carefully.

809. Can I ask the RCN a question about conflict of interest, in relation to the evidence you have given, in Appendix 5, about regulation of children's health care outside the NHS, and you express a number of serious concerns, including the fact that the age range of the children being dealt with has changed, so that units which previously did not admit children under eight are now admitting toddlers, even if they lack the necessary equipment, facilities and experienced staff. And one of the things that you highlight as well is "Poor recognition and management of pain, as the staff are not skilled in identifying or treating children's pain, with some doctors still believing that young children do not feel pain." And you then say: "Nurses who express their concerns over standards of care being told if they are not happy with the practices of their employer they should seek alternative employment." Now it may be argued, and was argued effectively by the BMA witness in relation to doctors, well, alright, they can go and work elsewhere, but that does not seem a very good solution, and the RCN clearly does not think it is a good solution, and, of course, people may well have lots of reasons for wanting to work in a particular place. So what do you think? You are identifying there a clear conflict, that there is pressure, you are saying, being brought, in some instances, you are very careful to say that there are examples of good practice outside the NHS as well, but you highlight this. What protection do you think nurses should have, what should they be able to do, in circumstances such as you describe?

(*Ms Taber*) Can I say, the Appendix that we did on the children's issues was from the Health Select Committee that looked at children's issues, and it is evidence that the RCN has been collecting for a considerable amount of time. Because that was collected over the last few years, we decided to do another questionnaire, in conjunction with our Paediatric Nurse Managers Forum, and we have circulated 241 questionnaires to the independent sector, of which we have 109 responses;

unfortunately, we have not had a chance to analyse it yet. But we stick by our original evidence, that there is excellent practice out there in some units, but, I think, the children's issues does need to be raised as an area that we need to put some very strict guidelines on, and the future regulation system must be very aware of what is happening to children, and I think the throughput needs to be monitored. So it does put, often, a business accountability, versus a professional accountability, on the nurse, and that needs to be addressed.

810. So should the nurse, in such a circumstance, be entitled, and be protected if she does do so, to report this to the Department of Health, for example?

(*Ms Taber*) In the independent sector, the reporting mechanism would be via the Director of Nursing, who would then take it to the MAC. But, also, if that mechanism does not work then there is the registration and inspection link, which is a system that should work with, and particularly in a new, proposed system, that registration inspection officers will be trained, and presumably be trained in this advocacy role.

811. But will a nurse be protected, if she makes such a complaint, or draws attention to bad practices?

(*Ms Taber*) Yes, we have areas where we know that perhaps the nurse has not been protected, and this certainly does need to be raised. One of the areas that I would like to bring in there, I think the Independent Healthcare Association has a very good role in raising these issues and making sure that the whole of the sector is aware of pressures that could happen.

812. Your evidence exposes, in fact, what I think is an unsatisfactory position, in relation to the Department of Health. You mention that, in February 1997, you wrote about this, and the Department of Health replied like this: "The position of the DoH on this is as follows. Standards for the care of children in private facilities, whether they be in a NHS hospital or a private hospital are not the concern of the Department." That was very unequivocal. It has been softened a little bit since then, with the change of Government, to a reply in January 1998, which stated: "Children receiving private care in NHS hospitals should be provided with the same standards applicable to any other child." But then you say this information has not actually been sent out to NHS managers, and so you are suggesting that they are not very aware of this change. But the Department of Health letter also says: "The responsibility for ensuring that appropriate standards apply to children in the private sector must lie with the parents and those purchasing and providing the services." I take it that the RCN would not be happy even with that softened stance of the Department of Health?

(*Ms Taber*) No, we would not. I think there are enormous opportunities now to work much more together with the independent sector and for the Department to recognise the independent sector, and the Government to recognise it, because there is some excellent practice out there. There is a Forum at the Department called Partnerships with the Independent Sector, which the key independent

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Audrey Wise Cont]

sector managers go to, and we have raised this on a number of occasions, that the Department does not want to mention in documentation the independent sector, the whole issue around clinical governance, it only says in the NHS; if it said in health care then it would apply to all of it. The Information Technology Strategy, where the targets are just enormous, for every patient to have an electronic patient record, it was by the year 2002 but now the year is 2005; the independent sector has not been involved in that, so there is just no way that is going to happen. I think the time is right, after this Committee has reported, to actually go forward and work much more in partnership and address these issues together. Going back to children, they are a very vulnerable part of our population and we have got to make sure that they are treated right, wherever they are nursed, and I believe the NHS pay beds needs to look at their protocols, as well as the independent sector.

813. Nurses are frequently the people who are the most aware of deficiencies, in equipment, or in care, in many ways, and do you think that there should be specific protection against victimisation for what you might call a whistle-blower in this?

(Ms Gough) I think, wherever you have a situation whereby a nurse is forced to resign, or is sacked, for having blown the whistle, where care is unsatisfactory, that the whole system has failed; that does not serve patient care at all, it does not serve the nurse's particular position or the company's particular position. What would be far more satisfactory is not only putting in place safeguards to protect people who do blow the whistle but actually to have a system whereby you never reach that particular point of confrontation. And what we often find with nurses is that, where nurses are included in the design, the management and the leadership of packages of care, those situations will never happen where a nurse is suddenly put in the position of having to protest that a particular standard of care is not being met, or a particular situation is dangerous, because, by the very fact that they were involved in the design of that care, that situation is not going to arise. Where nurses are forced to blow the whistle, one of the avenues is, as Sally has said, through the registration and inspection authority, those complaints can be confidential and anonymised, but in very small, independent institutions it is quite obvious, sometimes, who the complainant is, and nurses who have been at the point of making a complaint have known that that would be treated anonymously but have still felt they have had to step back, out of that employment situation, at that point of making that complaint. To look at ways of protecting nurses would be quite difficult, I think, in relation to that, if someone leaves in a small institution.

Julia Drown

814. I would like to ask the BMA to clarify a couple of points on Medical Advisory Committees. It seems clear you think that these Committees are the best route for regulation, but, surely, they need some additional accountability to ensure they are effective. If you compare them to the parallel in the NHS, there is the route to go on to independent reviews, where

somebody would investigate a case, or a difficulty, who was completely outside the hospital in which that person was practising, and there is not that sort of parallel at that level within the private sector. So I would like you to comment on that, and comment on whether you think there need to be some sort of sanctions if a Medical Advisory Committee is not doing its job and is not seen to protect patients.

(Mr Machin) Yes, I think that is taking it on a little bit further, because what we are actually talking about there is a complaints procedure, rather than just the clinical governance. We are at the moment developing a complaints procedure for the private sector; this is really quite a difficult area, because, frankly, the example we have in the Health Service is so flawed. The current complaints procedure in the Health Service is not working in the way in which we hoped it might do, it does not seem to be satisfying the complainants, and the doctors involved, neither the assessors nor the people against whom complaints are made, seem to be very happy about it, just on the survey, and about 50 per cent of both groups were less than happy with the way in which the system worked; so we have a problem over a complaints procedure. Within the hospital sector of the private sector, if I might put it like that, at the moment it works through the MAC, and we think that that is probably the right way to go, that a complaint initially should be addressed to the doctor who provided the service, and if it cannot be resolved at that level then it should go on to the MAC, who could then appoint a group of doctors to look into it and see whether it can be resolved at that stage. Now, if it is not resolved at that stage, at the moment, that is where it stops. What we are hoping to do is to develop a system whereby there is some independent review not dissimilar to the Health Service independent review mechanism, and, also, and, again, this is very much open to debate, we would like to see the final option of the Health Service Ombudsman being able to look at complaints which really are not resolved and which are reasonable. The other thing which I would personally like to see is that complaints be looked at by an independent person, not a doctor or anybody to do with the hospital, but somebody who was actually trained, preferably probably a clinical psychologist, to talk to the complainant, especially when it is not clear exactly what the nature of the complaint is; sometimes, as you, as Members of Parliament, will be aware, you can get very diffuse complaints, and there are complainants whose complaint is never going to be satisfied, whatever happens, if the individual against whom they were complaining were hanged, drawn and quartered that still would not be a satisfactory resolution of the complaint. But there are also people for whom the complaint has been triggered by problems outwith the medical intervention; very often this is relatives complaining, when the underlying problem is actually guilt on the part of the relative. And if you regard a complaints procedure as being something in which you are trying to resolve the issue, rather than necessarily apportion blame, then I think there might be some argument in bringing in somebody who can actually talk through the complaint with an individual and try to get to grips with their perception of the complaint, and try to help them to come to terms with a problem which

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Julia Drown Cont]

may be different from that which it appears at first sight. This is just a proposal that I have, to try to do something which is actually more useful than a lot of the present system, which seems to allow complaints to go on and on and on, and at the end of it they are never resolved to the satisfaction of the complainant, and it seems to me that if we keep on just ploughing the same furrow we are not necessarily giving the sort of level of satisfaction that is possible.

815. On the clinical governance point though, what is the sanction, if a particular private hospital is not pursuing seriously any issues over clinical governance?

(Mr Machin) There are a number of sanctions. One of the sanctions would be the insurers, because the insurers are interested in quality. Another sanction, which I have personally applied, is not to use the hospital; as a consultant, you often have a choice, and I chose not to use a certain hospital, because I was not satisfied that the standards in that hospital were up to scratch.

816. But if you are the consultant who is the one with poor practice, you are not likely to do that, are you?

(Mr Machin) That is true, but remember that, the question of poor practice, that bounces back every time onto the colleagues of that practitioner, other doctors in that hospital; and it is worth repeating that other doctors' registration is vulnerable, if they choose to ignore poor practice in a colleague.

817. But can that really apply in the private sector? I can see that it can in the NHS, where you are working in a team, you are continually communicating with other colleagues, you are talking to them about patients whom you will be covering for them over the weekend, and so on. In a private hospital that does not work in the same way, does it, because you go in, you book your theatre session and you leave again, you have no responsibility for other people's patients? So how can one consultant in that private hospital really be held to account for an activity of another colleague in that hospital whom he, or she, might hardly ever see?

(Mr Machin) If you never see them and you never come into contact with them, that would be perfectly correct; but one of the things we have proposed is that each specialty working in a private hospital should have a representative on the MAC and that there should be better communication between that representative and other members of that same specialty in the hospital, so, in other words, we want to build in these sorts of mechanisms where there is communication between specialists in a given specialty.

818. But that is a proposal and is not happening at the moment?

(Mr Machin) That is not happening at the moment, no; this is very much an evolving situation. But, the fact is, when things start to go wrong you do find out about it, because, although you may not be responsible for that person's patients, if there is a problem whoever is around will get involved, I can assure you, in the private hospital. And most of us within a specialty have arrangements with our colleagues in that specialty whereby if there is a problem with one of our patients the nearest

available member of the specialty will deal with it; so if another colleague was in theatre and one of my patients had a problem that colleague would expect to be asked to see the patient, not that it would be something unusual. So, if somebody, one individual, were constantly having problems with their patients, the rest of the specialty would very rapidly become aware; and nursing staff are very good conduits of information, whereby one actually hears in theatre, if there are problems, you hear about it. And, if you have been told, you then have a responsibility, it does not have to be from a doctor, but from members of the nursing staff, or an ODA draws it to your attention, and you have a responsibility.

(Ms Taber) I think nursing staff have a huge role in this, and the consultants that come in to work in the hospitals are not employees, so the nursing staff are very much in a role that they recognise poor practice and do bring it to the attention, via the Director of Nursing, via the MAC. And, certainly, when I was a Director of Nursing, we operated that system, that the senior nurses brought their concerns and were interviewed. And, I think, with what has come out in some of the independent sector concerns, it is terribly important that one involves nurses, and we are a profession that should be involved in the management side as well as the clinical side, and I think that should be encouraged.

819. Just one final point on this issue. If the proposal that is being produced by the BMA is carried out, is there not a problem there, that consultants might not want to do that? One of the attractions of private practice is that they can do the paperwork in their own way, they can, largely, work on their own. And one of the complaints you hear from consultants in the NHS is "there are always too many meetings, too many comparisons, clinical audit, all these other things, I have to do" and, in a way, it maybe some relief for them to go into the private sector and work. If then there were those extra burdens being put on them in the private sector, is there an issue there about trying to get consultants to sign up to that practice in the private sector as well as in the NHS?

(Mr Machin) I hope not. Obviously, one has to make these things workable, which is why we propose that there should be a rolling form of audit, for instance, which did not necessarily involve individual practitioners, in other words, it was a morbidity, mortality, complications audit, which the hospital could carry out, and many do already, I have to say, quite outwith the practitioners' involvement. So that, we felt, was our fall-back position. For those practitioners who are working in the Health Service, and most, the vast majority, of consultants who carry out private practice also are working in the Health Service, clearly, their audit is going on in the Health Service as well. And there does have to be communication, we feel, between the private sector and the Health Service when there are problems, or there are perceived to be problems, about the practice of a doctor.

820. Can I ask just one thing about outpatients clinics? You said in your evidence you thought we needed to look at dietary clinics, impotence clinics, and so on, and you have said clearly how there is an issue about making sure people have the right

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Julia Drown Cont]

qualifications to work in a particular area—you mentioned titles and making sure practitioners are talking to the GPs and looking at patients' notes, to make sure practice is professional. But where would you see the limit to that? Would you say that absolutely every sort of health care needs to be regulated in that way, and I am thinking particularly of homeopathy, Chinese herbal medicine clinics. Would you say, if it has got anything to do with health care, you have to go through this sort of regulation; or would you say there are some things that can be kept apart from these regulatory practices?

(*Mr Machin*) I am talking about the activity of registered medical practitioners, basically. I think, though, that the problem with non-registered practitioners really is identification, and I think Parliament might legitimately look at the question as to where the boundary does stop, because, at the moment, it does not stop anywhere. And somebody, as far as I can see, can describe themselves as a surgeon and offer surgical treatments without necessarily indicating that they are not medically registered, patients will assume that people are registered; and if you look at the qualifications, for instance, of chiropodists, you need to have some knowledge to know that they are not surgical qualifications. There are real problems. And just about a fortnight ago I saw a patient, in the Health Service, with severe problems, I had been seeing him on and off for a while, and he said that he had seen various alternative practitioners; he then said that he had got a medical report from a doctor he had seen, which he then handed over to me. I said "Who is it for?"; "Oh, it's for me." I said "Doctors don't write medical reports for patients; we talk to patients, we write medical reports for third parties." So I looked at this medical report, and the person concerned described themselves as "doctor", and in small letters "(ac)", and he had his qualifications down, none of which included a doctorate or a medical degree. This person thought he was dealing with a registered medical practitioner, he said "Well, everybody calls this person 'doctor' so and so"; they might do, but he is not. I sort of highlighted to me the kinds of problems that we are into, where people think they are seeing doctors and they are not; and it is the same phenomenon in the plastic surgical trade, where they think they are seeing a consultant and they are seeing the salesman. And it is an area which is outside medical regulation, but it certainly ought to be an area, I think, that your Committee ought to look at, Chairman.

Chairman

821. Ms Gough, do you want to add something, briefly?

(*Ms Gough*) It is just that the commentary that is going on at the moment, in terms of looking at robust systems of regulation for the independent sector, particularly the acute sector independent services, as has been said, the MAC covers medical practitioners only; we are talking about whole systems, whole institutions of health care here, which are multi-disciplinary, and to have a system which is non-statutory, no statutory imperative at all, but only

deals with one set of practitioners, is actually not provision for a robust regulatory system for this sector. Sally will give you the statistics that the acute sector provides; how much surgery, Sally?

(*Ms Taber*) Twenty per cent of surgery; but I hope that we are going to go on to perhaps the overall system, because, I think, from the RCN's point of view, we are concerned that it is—

Chairman: I think that Robert Walter may want to come on to exactly that point in a moment or two, so I will bring him in now.

Mr Walter

822. I wanted to talk about regulatory frameworks and regulation of the sector and how that might fit in with regulation of the National Health Service sector, the public sector, as well. I will direct my questions, if I may, to start with, to the RCN, and I will bring in the BMA. But you dealt at some length in your evidence to us about that, and you said the regulation, inspection and registration of the acute independent sector currently seems to be 'tacked on' to a system designed primarily for the regulation of providers of long-term nursing home care, and obviously we are talking about the Registered Homes Act. Now you, in your evidence, advocate that the Regional Commissions for Care Standards are the best location for regulating the sector; now that is actually a minority view, in the evidence that we have taken. I wonder if you would like just to explain why you think the Commissions for Care Standards would be the best place to locate this?

(*Ms Taber*) We believe that the Government at the moment have got an excellent opportunity to look at the whole system, as a whole, rather than split up the sector again. The Commissions for Care Standards are going to be an independent regulatory framework, of which we have been lobbying for some time to get. Before I go on to the reasons why we think that we should be using the Commissions for Care Standards, we do have concerns at the way they have been presented at the moment, and that it is entirely in Modernising Social Services, and the next paper Assessing the Performance of Social Services that has come out is all about social services; so our recommendation would have the underpinning that the health component in this is raised tremendously. We have really got to make sure that there is a partnership between social and health, and we are very worried about the nursing in nursing homes, at the moment, in Modernising Social Services, because you can hardly find the word health, and that has to be corrected, and we have got the ideal opportunity to do that. From one separate system, from economies of scale, from cost-effectiveness, from a registration and inspection inspectorate that is trained to cope with all of the aspects of health care that goes on outside the NHS, we feel that this is an ideal opportunity. Obviously, long-term care is just one aspect of it, the mainstream, acute hospitals are another aspect of it. The growing number of clinics that have been talked about this morning, the walk-in clinics, the abortion clinics, fertility, circumcision, you only need to switch on the radio and you can have your hernia done, you can have whatever you want done. So, the Commissions for Care Standards,

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Mr Walter Cont]

it is an ideal opportunity. If you split off the mainstream sector, together with the clinics, I think you would have a very fragmented system, and there are a number of grey areas there. Can I give you an example of a few grey areas that would happen?

823. Yes, indeed?

(Ms Taber) For instance, there is a centre on the South Coast, called the Horder Centre, which is a centre for dealing with arthritis; they actually have 24 surgical beds, where they deal with hip replacements and all of the range of orthopaedic surgery, but they also have 35 nursing home beds; because their surgery is fairly busy, they use some of those nursing home beds to nurse their post-operative, surgical patients in. If you split the regulatory system, you would have registration and inspection officers going in from the Commissions for Care Standards to what they thought was 35 nursing home beds, it may sometimes be 30; then you would have the other part of the hospital under something else, or under nothing, at the moment. Another example, of a nursing home dealing with palliative care having 8 to 12 hospice beds. I think we have to think very carefully before we split up the system. The Government have talked about bringing down the barrier between health and social; if we build another barrier, that puts up grey areas between the acute sector and the long-term sector, I think it will be a mistake. So those are our reasons. You have a super opportunity to address the whole of the registration and inspection framework, and, as you can see, in our evidence, we have started work with that, and had started work with that in 1994, so we would very much like to work together with other organisations to try to get the health component raised in these Commissions for Care Standards. We are very aware that NICE and the Clinical Frameworks, the clinical governance agenda, must apply to the independent sector; obviously, any national framework on cancer, on mental health, the independent sector has to follow that. So there is an ideal opportunity to have a very flexible system and to acknowledge what some of the mainstream hospitals are undertaking quality systems, that that should be acknowledged as well, so any registration and inspection officer going into those kinds of set-ups would know that that was happening and be able to adjust their inspection accordingly. But we are in danger of looking too much at the mainstream hospitals and not including all these clinics that are just growing so rapidly, and I think we have got to get to grips with that and the RCN sees the Commissions for Care Standards as the ideal opportunity to do that.

824. You do not think that, if one is culturally biased towards the nursing home sector, and they may not be the most appropriate body to be looking at acute hospitals, if one looks into the public sector, looks at the National Health Service, looks at hospitals in the National Health Service, which may well have palliative care beds, and all the other things that you describe, they will be coming under a different framework, we will have CHI looking, inspecting those hospitals, should we not have the same framework right across public and private sectors?

(Ms Taber) Certainly, that is an option, to have the same framework across the public and independent sectors, but I do not think it is feasible at the moment, and how would you bring in all of these clinics, etc. If you are starting off a new body with a bias towards one sector then that is very sad. I think you have got the ideal opportunity to have a very broad look at the whole issue, and this is, obviously, the purpose of this Select Committee, to unpick the system and say, well, this is the ideal way forward. I am aware that our evidence is in the minority, but we actually have seen the very grey areas between health and social, and whether it is a social bath, or whether it is a health bath, or not, we are breaking that down; we do not want to build up another barrier. I think there is a huge opportunity to have a totally flexible system, as we have said, but with the Commissions for Care Standards and the independent regulatory framework being responsible and with registration inspection and officers having different skill mixes. One of the things that we have not mentioned is the mental health side, and I think I have talked to you before about the vast growth of mental health in the sector that the sector is caring for, as you know, 20 per cent of NHS patients, 55 per cent of forensic psychiatry; there is a huge opportunity to get a really excellent registration inspectorate that has all of the skills, or to bring them in, as they do at the moment, for specialist advice.

(Ms Gough) Can I just add to that, as well, that the NHS Trusts are accountable, ultimately, to the Secretary of State; the whole range of services being offered in the independent sector do not have that same line of accountability. Now if there is not a regulatory system that actually ensures that the safety of patients is put first in those sectors, the patient has no system at all to link into, in terms of pursuing complaints or protection.

825. I am not trying to suggest that there should not be a system, I am trying to get a common system. I wonder if Mr Machin might like to comment, because your members are going to be practising, and currently do practise, under both regimes, in the private sector and in the National Health Service; would you not see that there should be a common framework between both sectors, as a way forward?

(Mr Machin) I think there is a lot to be said for setting common standards and having an inspectorate of some description which is capable of inspecting to the same standard across the sectors. Now, clearly, there is a whole series of different ways that could be achieved, and through the Commission will be one method of achieving it, it could be through the Commissions for Care Standards, as another, although, I must say, I am slightly anxious, there, that we might get a divide between the private sector and the Health Service. I do not know a lot about the Commissions for Care Standards, I have to admit. But one does not want to see divides certainly between the Health Service and the private sector; because I think we have to accept that the Health Service is the bedrock of medical practice in the United Kingdom, and the Health Service sets the standard against which others should be judged. And I think that we might see a situation where the Commission for Health Improvements was involved, possibly setting the framework standard; we do not

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Mr Walter Cont]

know enough about the Commission and how it is going to work yet to be sure that it would be totally appropriate. And one of my anxieties, for instance, is that CHIMP is, I think, proposing a sort of four- to five-year cycle of hospital inspection, whereas, at the moment, in the private sector, the local health authorities inspect about every six months. So there is a problem around that, that it may well be that CHIMP sets the standards and the framework but the work is then done by another body on its behalf, possibly local health authorities, but working to the same standards. Because the private hospital organisations have a legitimate complaint at the moment that the standards are different around the country and are determined by the local health authorities rather than by some central framework, and that private facilities in the Health Service are not treated in the same way as private facilities outwith the Health Service. So, clearly, there are problems, and this is, I would totally agree, an ideal opportunity to come up with a better system than we have at the moment, although I think it is very much open as to which system ought to be used and how it ought to integrate with CHIMP, if CHIMP is actually brought in to the private sector.

826. My understanding is that CHIMP may well be looking at hospitals on a tighter cycle than that. I was in our local hospital last week and they were talking about a two-year cycle. And they will operate rather like OFSTED does, if you like, in the education sector, they will be setting the standards, there will be a national set of standards. But do you not feel that it is their standards that the whole health service, public and private, should be complying with, rather than having a different body which, whatever we might say about it not being nursing home biased, is going to be nursing home biased? Because we are looking at some pretty big, acute hospitals here, which are in the private sector, as well as a lot of other people who are carrying out acute procedures, carrying out surgical procedures, which should be regulated by the same standards as if you walked into St Thomas' Hospital to have the same thing done. Do you not think that is right?

(Mr Machin) Yes, I thought I had actually said that. I do think the standards do have to be the same, or similar, because, obviously, there are certain differences between the way the private sector works and the way the Health Service works, but the standards have to be equivalent across the two sectors. And, therefore, the logic of that is that the frameworks produced by CHIMP should apply, with modification, across the two sectors.

Chairman: Can I say, I do feel we need to curtail this first session, which has been extremely valuable, by mid-day. We are running rather late, and some of my colleagues do have further questions. Could I appeal to my colleagues for sharp, crisp questions, with the key points, and for crisp answers from our witnesses. John Gunnell.

Mr Gunnell

827. I think you have made it clear, really, your attitude on the particular issues I was going to talk about, because you have asked for, in effect, a single system of regulation, and I presume you would like this Committee, when it has finished taking its evidence, to be recommending that?

(Ms Taber) Yes, we would.

Mr Gunnell: You can divide the thing more or less on a grid into four sectors, because you have got the NHS sectors and you have got the independent sectors, and you have got non-acute and acute, in each of those sectors. But you would like to see a system which applies in a consistent way across the four, and it is a question of deciding what body, whether the Commissions for Care Standards is a suitable body, or whether there is some other body that might be suggested, or whether, in fact, some new system has to be devised to do it. But we do need to get something which is consistent, and I would take it you would think we would need something which is also fairly tough; because, as you say, when you look at the mainstream providers in the independent sector you get a very different picture from when you look at the sector as a whole. And what we have found is that when we have talked to the mainstream providers, and with the people that we saw yesterday, they would welcome regulation, but they would welcome regulation in part because it is seen as differentiating them from those that are in it for different reasons?

Chairman

828. John has responded to my request for crisp questions; that is one of his crisper questions, actually. Can we have some brief answers, please?

(Ms Taber) We want to impress that flexibility is important.

(Ms Gough) And also that CHIMP does not have registration or a function of issuing licences, it enforces quality standards but it does not have a licensing function. If you want to create a whole new system, over and above CHIMP and the Commissions for Care Standards, then that is up for discussion, but it seems like we have a very good system already being recommended that can be enhanced by CHIMP.

Mr Gunnell

829. Then let me just expand in one way. Would you feel that the Mental Health Commissioners should be expanded so that they become the regulator of the independent mental health sector, and that should cover the whole range which you talked about, from the forensic psychiatry to the non-acute nursing homes for mentally ill, elderly people?

(Ms Taber) No. As we have said before, the registration and inspection body needs to have the skills to deal with the whole of the sector, and mental health is not entirely in its own little sector that is split off, one nursing home, one hospital can have mental health in it, it can have surgical, it can have a variety of different specialties. So the Mental Health Act Commission, I think, does a superb job, and if you read some of their reports they are absolutely excellent about the way they either say the independent sector is doing well or it needs to address problems; it does not have an enforcement function. If you actually looked at that way forward, you would have to resource it in a different way. We feel that the Mental Health Act Commission should

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Mr Gunnell Cont]

work in conjunction with the new independent regulatory framework, the new registration inspection, they must have registration and inspection officers with mental health skills; there is a lot more than just what the Mental Health Act Commission does.

830. Yes, but they have an important role, but it is not a role which covers the whole task area?

(Ms Taber) No, I hope I made that clear.

Julia Drown

831. It is about disciplinary procedures; the RCN, in its evidence, said that a high proportion of your cases relate to the independent sector, and I would like to know the reasons for that?

(Ms Taber) Actually, it was not our evidence. I think you have probably in but it is something that, obviously, we have followed. And I made sure that I got up-to-date figures from the UKCC yesterday, and, yes, the independent sector has a complaint rate of 25 per cent, of which the majority are from nursing homes. But we would see that as because of the size of them, for a start, they do not have the infrastructure that a Trust would have, so if there is a complaint about a nurse in a Trust then it does not go straight to the UKCC, it goes up through the systems in place. There is a lot of financial pressure put on the nursing home sector, at the moment, with the lack of finances for the care that they are giving, and one of the areas that the UKCC talked about yesterday was the aspect of commercial pressure there, that there just is not the finance, so owners are cutting some of the financial aspects and, consequently, nurses are not having the right equipment to nurse with; so this is one of the reasons. Mr Machin has already talked about extending the complaints system in the independent sector, and we think that that will have a beneficial effect on the aspect that you have just talked about. If you put it in perspective, I do not think it is tremendously high, but, certainly, from the College point of view, we do find out from the UKCC exactly what the complaints are, and look at perhaps the broader reasons why this is happening.

832. And, for the BMA, I would like to know why it is acceptable for private clinics to continue to use doctors who are no longer able to work in the NHS, who have been stopped from working in the NHS?

(Mr Machin) You are talking about people who have been suspended?

833. Yes?

(Mr Machin) Suspension, in the Health Service, is supposed to be a neutral act, and suspension in the Health Service does not necessarily imply that that doctor is clinically unsatisfactory; so we have got to be very careful here, how we actually define it, because people have been suspended, and are suspended, for personal misconduct, which has nothing whatsoever to do with the way in which they look after patients. There are people who are suspended, most of the doctors who are suspended are subsequently reinstated. There are a lot of managers who fire off from the hip and have people suspended for really quite trivial reasons.

834. But sometimes people are suspended for things that turn out to be very genuine reasons?

(Mr Machin) Absolutely. I am just setting it against its background. So what we would say is that if somebody were suspended from the Health Service because of a serious, clinical problem, that was not just related to one area, for instance, if there was a problem with somebody's practice, laparoscopic surgical practice, then what we would say is that in the private sector they should not practise laparoscopic surgery.

Chairman

835. Who would judge that, who would determine that?

(Mr Machin) In practice, it is the MAC and the hospital manager, when they get to know about it, and possibly the major insurers sometimes get involved as well.

Julia Drown

836. But do you not think the public would be comforted to know that as soon as somebody was suspended from NHS practice they would also be suspended from private practice, until the problem is resolved?

(Mr Machin) They might be, but there is a difference between the two sectors. In the Health Service you are at least paid; in the private sector you are not. And there are quite significant issues, legal issues, around liability, on this, because, if an individual is suspended, possibly maliciously, in the Health Service, they could bring an action for damages against the private hospital and against all sorts of people, subsequently, when they are then reinstated into the Health Service. So, I think, while I am not in any way suggesting that somebody against whom there is a serious, reasonably founded complaint of poor practice should continue in the private sector, it would not be right to say that, because somebody has been suspended in the Health Service, therefore, as a natural consequence of that, they should not practise in the private sector. We do have to look at each case. And that is what we say to all of the insurers and the private hospitals, look at it.

Chairman

837. So you are implying that there can be a series of categories of suspension?

(Mr Machin) Exactly.

838. From which certain problems would be extracted, and that would impact upon the private practice; broadly, that is what you are suggesting?

(Mr Machin) Yes, that is right.

Mr Lewis

839. Mr Machin, do you actually have any evidence that the private sector is a haven for sub-standard doctors, is there any evidence of that?

(Mr Machin) I am not aware of any evidence, no. I have to say, I have no evidence that that is the case. And, certainly, it is in no way in the interests of

29 April 1999]

MR DEREK MACHIN, MS SALLY TABER
AND MS PIPPA GOUGH

[Continued]

[Mr Lewis Cont]

mainstream private medicine to allow sub-standard practice, it is not in the interests of the private hospitals to get involved with high profile, serious professional misconduct. There is a commercial imperative, on the part of the private hospitals, to make jolly sure that they do not allow people like that to practise.

840. Is there any mechanism though to measure practice between the sectors, is there any mechanism that exists where information is collected which will allow you to make a judgement about the answer to that question, or is it that the information is not available?

(Mr Machin) The information, to my knowledge, is not available.

Chairman

841. Are there any further, quick questions from Members; if not, do any of our witnesses wish to add anything, specifically?

(Ms Taber) Could I just add, very briefly, in other sessions, you have talked about the NHS losing nurses to the independent sector. I think there is an

opportunity for a much more formal approach to clinical placements in the independent sector, student nurses, post-basic nurses, to go to the independent sector for experience. It is happening. Just a figure, General Healthcare Group actually had 288 clinical placements in 1998, so there is the opportunity there for the NHS and independent sector to work together; and, rather than lose its nurses to Marks & Spencer and British Airways, it would be far better if they had the opportunity to go between the two sectors. And I guess my last point is, 25 per cent of our members work outside the NHS. I just would like to think that we could speak more positively about the sector and about the work that they do, because there is excellent work being done in the independent sector.

Chairman: Thank you. Can I thank all of our witnesses for your co-operation this morning; we are most grateful. We are sorry we kept you so long. And thank you, once again, for your written evidence. Thank you.

Memorandum by the General Medical Council

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTH CARE (PM 102)

INTRODUCTION

1. We have been invited to submit a brief memorandum in advance of presenting oral evidence to the Committee on 29 April 1999.

SUMMARY

2. The GMC makes no distinction between doctors in the public and private sectors. Our guidance on the undergraduate curriculum provides a common educational base for all UK qualified doctors, whatever career path they subsequently choose; the medical register includes all doctors licensed to practice medicine in the UK, whether in the NHS or privately; our guidance on standards of professional conduct applies to all registered doctors; our fitness to practise procedures apply to any registered doctor whose fitness to practise is in doubt. The GMC has no jurisdiction over health care organisations.

3. This memorandum describes our key functions and how we are attempting to raise standards and protect patients through our existing procedures, proposals for revalidation of doctors' registration, and improved sharing of information with other bodies concerned with medical regulation.

4. The culture of medical practice in the UK is changing, and we are playing our part in leading change. An article by the GMC President, Sir Donald Irvine, published in *The Lancet* in April 1999 (*The performance of doctors: the new professionalism*) (Annex A)¹ discusses the quality agenda before the profession and the GMC. We recognise that in modernising medical regulation, we, together with others, must pay particular attention to the practice of medicine outside the NHS. The basis for achieving quality assurance within the private sector is the same as it is in the NHS, although the mechanisms may be different. Just as we have discussed quality assurance with the chairmen and chief executives of NHS trusts and health authorities, so we have opened discussions with the major private healthcare providers and insurers on ways in which they can improve their practice through:

- Securing compliance with the principles set out by us in *Good Medical Practice*.
- Introducing effective local medical regulation, based on quality-assured clinical teams.
- Making explicit the arrangements for identifying poor professional performance and, when appropriate, for reporting poor performance to us.
- Putting in place effective local arrangements to support revalidation.

¹ Not printed.

29 April 1999]

[Continued

THE ROLE OF THE GMC

5. The GMC's duties and powers are conferred and regulated by statute. Our current powers derive from the Medical Act 1983, as amended by the Medical (Professional Performance) Act 1995 and the European Primary Medical Qualifications Regulations 1996.

6. The GMC protects the public interest by regulating the medical profession. The GMC licenses doctors to practise medicine in the United Kingdom and has four main functions:

- a. Keeping up-to-date registers of qualified doctors.
- b. Fostering good medical practice.
- c. Promoting high standards of medical education.
- d. Dealing firmly and fairly with doctors whose fitness to practise is in doubt, on grounds of conduct, health or performance.

KEEPING UP-TO-DATE REGISTERS

The principal register

7. The principal register makes no distinction between doctors employed in the public and private sectors. There are about 180,000 doctors on the principal list of the register of medical practitioners. It is a criminal offence for a person to pretend to be registered when they are not (section 49 of the Medical Act 1983), although it is not an offence to practise medicine without registration. Only registered doctors may hold a medical officer appointment in the armed forces; in a hospital for persons suffering from a mental disorder; in any other hospital not supported wholly by voluntary contributions; in a prison, or any other public establishment body or institution (section 47 of the 1983 Act). Any certificate required by statute to be signed by a physician or surgeon is not valid unless signed by a fully registered practitioner (section 48 of the 1983 Act). Under the Medicines Act 1968 registered medical practitioners are appropriate practitioners for the purposes of prescribing medicines (section 132, definition of "doctor"). The NHS Act 1997 requires medical practitioners providing NHS general medical services to be registered (section 128, definition of "medical practitioner").

The specialist register

8. The GMC is required to maintain and publish a specialist register. Only those doctors whose names are included in the specialist register may take up most substantive or honorary consultant appointments in the NHS. This requirement does not extend to doctors working outside the NHS, although it is our understanding that the major private health insurers will only recognise specialists who appear on the specialist register. There are about 34,500 doctors on the specialist register. These doctors are also on the principal list of the register of medical practitioners.

9. For doctors who complete their specialist training in the UK, the usual route to the specialist register is the Certificate of Completion of Specialist Training (CCST) awarded by the Specialist Training Authority of the medical Royal Colleges (STA). EEA nationals who hold EEA specialist qualifications can also be included. There is provision too for doctors who hold specialist qualifications from outside the EEA to have their qualifications recognised by the STA for inclusion on the specialist register; as well as those to whom transitional arrangements apply.

Revalidation of registered doctors

10. In February 1999, Council decided that all registered doctors, including those practising exclusively outside the NHS, should be required to demonstrate regularly that they remain fit to practise in their relevant fields, and that this should be assured by a link with continued registration. This has become known as revalidation. Revalidation is the most important quality initiative to have appeared for several years within UK medical practice. A copy of our news release of 10 February 1999 is at Annex B².

11. Revalidation will seek to ensure that doctors' performance meets national professional standards. The system must be capable of involving all doctors, whatever their practising circumstances, and be open and transparent to the public, employers and the profession. In practice, revalidation will be based upon regular local profiling of a doctor's performance and continuing professional development. The local profiling process will be subject to periodic external peer review; periodic submission of evidence to the GMC would confirm the doctor's registration.

² Not printed.

29 April 1999]

[Continued

12. In a small minority of cases, significant shortcomings will come to light. If there are concerns about a doctor's performance, there would be local attempts to remedy the problem. Where local efforts are unsuccessful or inappropriate, the doctor would be referred to the GMC's fitness to practise procedures.

13. We will be working in partnership with the Health Departments to implement revalidation within the NHS. We will also be consulting and working with organisations representing the public, the profession, and health care management within the NHS and the private sector; discussions with the independent healthcare sector have already started. We aim to have prepared and approved a fully worked up model for revalidation within two years.

FOSTERING GOOD MEDICAL PRACTICE THROUGH STANDARDS

14. Our guidance on the duties of a registered doctor is contained in *Good Medical Practice* (1998) (copy at Annex C). This is a key document, which sets out the core guidance on standards of practice and care; working with colleagues; and probity in professional practice. The standards set out in *Good Medical Practice* are those against which we judge doctors if problems arise which call their registration into question. These standards apply to all registered doctors, whatever their field of practice or area of employment.

15. In July 1998 we published *Maintaining Good Medical Practice* (Annex D) which provides a framework for ensuring that standards of good medical practice are implemented locally through effective quality assurance. The booklet gives advice to doctors and managers on maintaining good medical practice through effective quality assurance and improvement in clinical teams. It also gives guidance on what to do when poor performance is discovered, and identifies the kinds of problems which may trigger referral to us. Although *Maintaining Good Medical Practice* refers explicitly to NHS structures such as health authorities and trusts, the principles apply wherever there are formal arrangements to maintain the quality of patient care.

16. Whenever Council approves new guidance—recent examples are *Seeking Patients' Consent: The Ethical Considerations* (Annex E) and *Serious Communicable Diseases*—copies are sent to all doctors on the register, as well as medical schools and medical royal colleges and faculties, all NHS health authorities and trusts and a wide range of medical and patient representative groups. Since *Good Medical Practice* was first published in 1995, we have sought to ensure that the guidance is understood and absorbed throughout the profession, and is reflected in undergraduate and postgraduate medical education. The Council has encouraged the active use of the principles of *Good Medical Practice* by those who employ or contract with doctors.

PROMOTING HIGH STANDARDS OF MEDICAL EDUCATION

17. The GMC's Education Committee defines and monitors the standards of undergraduate medical education. It decides the general scope of undergraduate education, with particular reference to the knowledge and skill and appropriate attitudes required of a doctor. The Committee's most recent guidance on undergraduate medical education, *Tomorrow's Doctors*, was published in December 1993.

18. The Committee also decides the experience to be acquired during general clinical training, which normally follows immediately upon graduation, to complete the transition from provisional registration to full registration. Our most recent recommendations were published in April 1997 as *The New Doctor*.

19. The Council promotes high standards and co-ordinates all stages of postgraduate and continuing medical education. In 1987, the Education Committee published *Recommendations on the Training of Specialists*. In December 1998, we published *The Early Years*, which sets out new recommendations on the training of senior house officers.

DEALING WITH DOCTORS WHOSE FITNESS TO PRACTISE IS IN DOUBT

20. Our fitness to practise procedures apply to all registered doctors, whether working in the NHS, the private sector or other areas of healthcare. There are three complementary sets of procedures: conduct; health; and performance. These procedures enable us to take action where there are concerns about a doctor's fitness to practise. Where appropriate, the doctor's registration can be removed or made subject to conditions.

21. We receive complaints directly from members of the public and other doctors. We also receive reports of investigations by bodies such as health authorities, NHS Trusts, private hospitals, the Health Services Appeals Authority, NHS Tribunals, coroners and the police. We are working with the Health Services Commissioner (the Ombudsman) on achieving close liaison with his office, and look forward to developing a relationship with the new Commission for Health Improvement and its equivalents.

29 April 1999][Continued

Sharing information

22. The only body to have a nationwide responsibility for regulating all doctors is the GMC. There are other bodies which have important roles in medical regulation, locally and nationally. They include employers, the medical Royal Colleges and faculties, the Ombudsman, and, shortly, the Commission for Health Improvement and its equivalents. We are reviewing the basis on which we can and should disclose information to other organisations about cases which have not completed a formal GMC process. We would welcome measures to improve the legitimate sharing of information between regulators and employers, and are discussing such steps with the NHS Executives and the Ombudsman.

23. While the NHS has its own complaints procedures, within the private sector, there is no national framework for responding to complaints. We are discussing with the main private healthcare providers and insurers what steps, if any, we can take jointly to protect patients.

CONCLUSION

24. The key ways in which we regulate private healthcare are the same as for the public sector. We therefore intend to strengthen the regulation of the private sector in the same way as we intend to improve regulation in the NHS, by setting explicit standards and discussing compliance with those standards with our partners. Just as we have discussed quality assurance with the chairmen and chief executives of NHS trusts and health authorities, so we are discussing with the major providers and insurers ways in which they can improve their practice through:

- Securing compliance with the principles set out in *Good Medical Practice*.
- Introducing effective local medical regulation, based on quality-assured clinical teams.
- Making explicit the arrangements for identifying poor professional performance and, when appropriate, for reporting poor performance to us.
- Putting in place effective local arrangements to support revalidation.

Letter from Mr Charles Akle, Council Member Independent Doctors Forum, to the Chairman of the Committee

PRIVATE PRACTICE (PM 6)

I understand that your Committee will be undertaking an inquiry into private practice in the Autumn and this is something that I and my colleagues in the Independent Doctors Forum welcome.

The IDF is a relatively young organisation consisting of practitioners who undertake predominantly private work and who are very anxious indeed that quality and standards are maintained. We consist of some 300 doctors and surgeons and our number is growing. We are a non partisan grouping of doctors. We are predominantly sited in Central London and have been very active in promoting, as I say, quality. My fellow council members have asked me to contact you to offer our support in your inquiry as between us I feel we know more about the subject than most and as we are independent practitioners we feel we can bring a degree of objectivity and experience to your inquiry.

In my own right I have also been successful in establishing a private practice forum at the Academy of Medical Royal Colleges with the support of a past president of the Royal College of Surgeons, Sir Terence English, and we produced a Guidelines for Standards in Private Care a copy of which I append for your perusal.

The document is relatively tame as compared to how I would like to see it but it may at least give you some food for thought and it is a start!

Finally I think it is important to establish that the majority of our members, many of whom are in primary care, do not view private practice as an elitist service but a rather as a means of maintaining choice and clinical freedom in these increasingly difficult times. We also feel that the way the insurance companies are forcing through changes in the provision of private care need very careful observation and control if we are not to make the same mistakes as our American colleagues.

I look forward to hearing from you if we can be of any service.

10 August 1998

29 April 1999][Continued

Memorandum by Independent Doctors Forum (PM 106)

Who we are and our terms of reference.

We have always had a form of audit of standards in the primary care private sector.

We are the reluctant "gatekeepers" for the private insurers.

Managed care and the inadequacies of the UK PMI system need urgent reappraisal.

All our patients are uninsured for primary care and the market sector for self-pay in the specialist sector is growing rapidly.

There is no private Health Ombudsman and the public and the profession is unprotected.

We are a major invisible export.

April 1999

Memorandum by The Medical Defence Union Limited**THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 70)****INDEX***Introduction**Executive Summary*

- Conclusions
- The MDU's Recommendations

*Promoting patient safety—current risks**Current regulation*

- Accreditation & Reaccreditation
- Market Forces
- Private Hospitals
- Professional Self-Regulation—GMC
- Local Self-Regulation
- Patient Complaints Procedure
- Private Dental Complaints
- Health Insurance Companies
- NHS Disciplinary Procedures
- The Civil Courts
- The Criminal Courts

*Summary**References**Additional reading***A. INTRODUCTION**

The Medical Defence Union (The MDU) is the UK's leading medical defence organisation. We were established in 1885 and are the oldest organisation of our kind in the UK. We provide indemnity and 24-hour advice and assistance with medico-legal and ethical problems to our members who include doctors, dentists and nurses. In the UK our members work in the NHS, community and private practice. They are held accountable for their conduct in a number of ways including: patients' complaints procedures, disciplinary proceedings by their employers and their registration body, and the courts.

*29 April 1999]**[Continued]*

The following statistics should help the committee to form an idea of the scale of our involvement in assisting members of the medical profession. In 1997 we took over 22,000 calls on our 24-hour advice line and opened 14,000 new files assisting members with complaints and claims on behalf of patients. We also opened 224 files replying to members' enquiries about the General Medical Council.

Our comments relate to our experience of assisting members with medico-legal problems in NHS and community, and private medical and dental practice in the UK.

B. EXECUTIVE SUMMARY

Conclusions

Accreditation and re-accreditation may have a part to play in ensuring that private patients receive an adequate standard of care. The principals that apply in the NHS could be extended to the private sector and could become a requirement enforced by the GMC.

Market forces do not apply uniformly across the board and cannot be relied upon to guarantee a good standard of care for the public.

Medical advisory committees in private hospitals are valuable in maintaining standards in private care, but their procedures need to be seen to be uniformly transparent and fair to all the doctors concerned.

Currently the GMC is the only means of regulating doctors' performance and maintaining high clinical standards across private practice. It has recently extended its disciplinary powers and is seen by most practising doctors as the final arbiter.

Local self-regulation may not be as useful as it appears at first sight. Although it has the backing of the GMC, it may be difficult to implement in the private sector. Local doctors in the same specialty may be in direct competition with one another and this could raise questions of a conflict of interest.

The local resolution part of the NHS complaints procedure has merit.

While independent review succeeds in its prime purpose of giving complainants a full explanation, it is not intended as a regulatory mechanism and there may be little merit in introducing a similar procedure outside the NHS.

Regulation through admission rights to private hospitals and recognition for payment by insurance companies may apply to most, but not all doctors in the private sector. Currently these methods of regulation cannot be relied on to protect the public.

The NHS disciplinary procedures cannot be transferred to the private sector as no blanket, contractual arrangements exist.

Medical negligence litigation is a blunt and inefficient instrument for regulating the medical profession. In addition to the sometimes considerable cost, it can be a slow and stressful process for both parties. Some patients clearly need financial compensation because of injuries they have suffered as a result of negligence. However, those who represent patients say that the single most common reason for initiating medical negligence claims is that they are upset at the doctor's attitude and feel litigation is the only way to get an adequate explanation for what has gone wrong. Many prospective plaintiffs also need reassurance that steps are being taken to make sure no other patient suffers in the same way. These concerns are more appropriately addressed through a complaints procedure.

C. THE MDU'S RECOMMENDATIONS

In the submission which follows we assess the existing means of regulating the medical and dental professions in NHS and private practice. Our recommendations are:

1. The GMC should clearly play a central role in any future framework for regulating private medical practitioners.
2. Consideration should be given to extending the Ombudsman's role to the private sector so that he becomes a national, independent assessor of patients' complaints. As the Ombudsman's report proved recently, when it highlighted failures in communication as a key problem area, it should be possible to build up a picture of some of the common areas of difficulty and to use this information to manage risks and to ensure patient safety.
3. The committee may wish to consider private dental complaints procedures in more detail as clearly they demonstrate that it is possible to regulate practitioners in private practice and to provide patients with alternative dispute procedures.

29 April 1999]

[Continued

D. PROMOTING PATIENT SAFETY—CURRENT RISKS

Our submission begins with our risk management department's analysis of some of the potential causes of harm to patients which have led to complaints and claims against members in private practice. The list is not exhaustive, and we could provide further examples, but it highlights some key areas that need to be considered when developing a regulatory framework which puts patient safety first.

- Advertising by some private clinics and hospitals may lead to prospective patients/clients being interviewed and assessed for surgery by unqualified personnel.
- In the case of plastic and reconstructive surgery, unqualified personnel (in many cases sales staff) may mislead patients/clients and give them unrealistic expectations about the outcome of surgery. This can increase the risk of a dissatisfied patient who may make a complaint or claim against the surgeon.
- Many cosmetic surgeons work country-wide and access to the surgeon post-operatively may not be easy. This can cause problems for patients who are discharged on the same day as surgery and develop complications once they are at home, particularly if follow-up arrangements are poor.
- Consent for treatment is not always fully informed and sometimes it is obtained by unqualified staff.
- Medical records and operation details are often incomplete or they do not give a picture that is clear and accurate enough for the continued care of the patient.
- In some cases the qualifications and accreditation of the doctors involved are not appropriate for the procedures undertaken.
- Doctors who work only in the private sector may find it difficult to take part in regular and systematic clinical audit as recommended in the new GMC guidelines.
- Medical staff who visit periodically may not know policies and procedures in private hospitals/clinics. This may be of particular concern in an emergency.
- Some practitioners work in isolation and may be unable to call for a second opinion in an emergency.
- Some resident medical officers (RMOs) may have limited experience and be expected to care for too many patients and too many diverse specialities, after hours. It can be difficult to contact specialists after hours.
- Team care is less likely to work effectively because the junior doctors do not always know the consultants with whom they work. In these circumstances policies and procedures are particularly important as a means of communication to ensure consistency of care.
- Intensive care and high dependency units are not always available on site.
- Staff in critical care areas may not be adequately trained and updated.

E. CURRENT REGULATION

Our assessment of the current means of regulating the medical and dental professions is set out below.

Accreditation and re-accreditation

There is no law or regulation obliging a doctor to have a higher qualification or specialist accreditation before offering specialist services in the private sector. However, the GMC has a specialist register and individuals have to be accredited, over and above a higher qualification (such as FRCS), before their names are accepted. If a doctor takes on work which is beyond his capability, he could be criticised by the GMC.

Medical royal colleges and faculties have their own by-laws, ethical standards and clinical guidelines, but the sanctions a medical royal college can impose against a doctor are limited.

This would change with re-accreditation which is currently being discussed. If it does receive the support of the medical profession and is adopted by the medical royal colleges and faculties and the GMC, it might be an effective way to maintain adequate levels of clinical knowledge and expertise.

However, re-accreditation will only affect those who seek accreditation in the first place. All specialists working in a senior career grade in the NHS could be required by the NHS to subject themselves to such re-accreditation. For the minority working full-time in the private sector, accreditation is, and re-accreditation will be, voluntary unless the GMC insists that it applies to all doctors.

Accreditation and re-accreditation may be useful for setting standards, but they are not absolute guarantees of a high standard of clinical care. An assessment of their effectiveness in setting standards is outside the scope of The MDU's experience and would be better dealt with by the GMC or the medical royal colleges.

29 April 1999][Continued

CONCLUSION

Accreditation and re-accreditation may have a part to play in ensuring that private patients receive and adequate standard of care. The principals that apply in the NHS could be extended to the private sector and could become a requirement enforced by the GMC.

Market Forces

Doctors in the private sector are subject to market forces more than those within the NHS. Most doctors in the private sector depend heavily on their reputation, particularly amongst NHS GPs and other colleagues who refer cases to them.

Market forces tend to regulate doctors most effectively in the early years of their career when private practice is being built up.

Most patients are unable to judge the relative standards of clinical care on offer, but with the relaxation of restrictions on advertising and the dramatic increase in the spread of information via the Internet¹ and other means, this is slowly changing.

Market forces generally demand a good “bedside manner”, and a doctor’s attitude tends to be a less common cause for complaint outside the NHS than within the NHS.

A small minority of doctors work for commercial companies advertising services such as cosmetic plastic surgery to the public. Very different market forces apply.

RECOMMENDATION

Market forces do not apply uniformly across the board and cannot be relied upon to guarantee a good standard of care for the public.

Private Hospitals

Most private hospitals regulate the granting of admission rights to doctors. Private hospital managers investigate adverse incidents and patients’ complaints through medical advisory committees. As well as promoting patient safety, maintaining high standards is seen as having commercial value.

In a few instances admission rights have been withdrawn from doctors in what appears to be a precipitous and arbitrary manner, but because of their contractual arrangements, individual doctors can rarely challenge these decisions. We have no experience as yet, but it is possible that the Human Rights Act 1998 could force a change in the way private hospitals withhold admission rights.

CONCLUSION

Medical advisory committees are valuable in maintaining standards in private care, but their procedures need to be seen to be uniformly transparent and fair to the doctors concerned.

PROFESSIONAL SELF-REGULATION

General Medical Council

The GMC regulates the medical profession. Its final sanction is the removal of a practitioner’s name from the register. Any person who gives a member of the public a false impression that he or she is a registered medical practitioner, commits a criminal offence. Because of its power over a doctor’s livelihood, no-one should underestimate the effect of a statement made by the GMC on day-to-day medical practice.

Among other privileges, registration with the GMC enables doctors to prescribe prescription-only medication. Any surgical operation needing a prescription-only anaesthetic requires, by law, the involvement of a registered medical practitioner or a registered dental practitioner. Exceptions to this are exceedingly rare: eg, a midwife may dispense pethidine, a narcotic analgesic drug.

The GMC has recently introduced a number of major changes that are transforming the regulation of the entire medical profession²⁵. All doctors are obliged to *audit* their clinical work and to follow GMC guidance aimed at ensuring a consistently good standard of patient care. Regulation within and outside the NHS is enhanced by the GMC’s new emphasis on the need for doctors to alert a proper authority if they believe a colleague’s health, conduct or performance is a threat to patients.

Anyone can complain to the GMC and it may investigate any aspect of a doctor’s professional work, through its *professional conduct, health or performance review* procedures.

29 April 1999]

[Continued

The *professional conduct* procedures are well established. Although the number of doctors disciplined by the GMC is small, cases attract a lot of publicity and have a profound effect on attitudes in the medical profession. The procedures have some drawbacks. The *Professional Conduct Committee* is limited only to investigating acts and omissions which may amount to **serious** professional misconduct.

The *health* procedures are also well established and generally work well, though they can be slow.

The Medical (Professional Performance) Act 1996 brought the *performance review* procedures into force on 1 July 1997 to overcome the limitations of the *professional conduct* procedures. National or regional *performance review* should be capable of regulating the private sector in the way that *clinical governance* is intended to do in the NHS. 18 months later very few doctors have been subjected to national *performance review*. This is probably due in part to its time-consuming and expensive nature, and also because it cannot consider any cases before 1 July 1997.

The current *performance review* procedure relies on complaints made to the GMC. The GMC is reported to be considering the need to introduce a *pro-active performance review* procedure.⁷ Such a procedure could clearly apply in NHS or private practice.

Procedures must be capable of withstanding a legal challenge from those who (directly or indirectly) lose income because of an adverse outcome. It will be very expensive to run *pro-active performance review* procedures which are seen to be fair and on the scale required, not only in terms of administrative costs, but also in terms of removing clinicians from clinical work to make the assessments. However, it is difficult to think of an effective alternative.

CONCLUSION

Currently the GMC is the only way to regulate doctors' performance and to maintain high clinical standards throughout private practice. It has recently extended its disciplinary powers and is seen by most practising doctors as the final arbiter.

RECOMMENDATION

The GMC should clearly play a central role in any future regulatory framework in private practice.

Local Self-regulation

A reason why so few of The MDU's cases have come to *performance review* is that the GMC has encouraged *local self-regulation* as a first stage in the process.⁵ Some NHS managers may use *local self regulation* to compliment clinical governance.

Unfortunately, *local self regulation* has had a poor start in some NHS hospitals, because of an apparent disregard for the principles of natural justice. The poor start may be partly due to the inexperience of those implementing it.

Adverse findings by *local self regulation* procedures can lead to an NHS doctor being *suspended or informally suspended* from duty pending a more formal disciplinary procedure. Some doctors who are suspended can also lose admission rights to private hospitals. NHS *suspension*, supposedly a "neutral act", may lead to a substantial loss of income.⁶ We have no experience, but under the Human Rights Act 1998 it could be easier to use the civil courts to challenge procedures which disregard natural justice.

CONCLUSION

Local self regulation may not be as useful as it appears at first sight. Although it has the backing of the GMC, it may be difficult to implement in the private sector. Also local doctors in the same specialty may be in direct competition with one another and this could raise questions of a conflict of interest.

Patient Complaints Procedures

Although there is no formalised patients' complaints procedure affecting all doctors outside the NHS, the GMC's new requirements² oblige all doctors to respond to patients' concerns and complaints quickly and sympathetically. For many years the MDU has advised members to give a full and candid explanation if something goes wrong and to apologise when appropriate. This concept has now been enshrined in the GMC's requirements.

Patient complaints outside the NHS are usually dealt with much along the same lines as the first stage or local resolution procedure^{3,4} within the NHS. This is a recent development, prompted by the GMC's new requirements and should soon be universal.

29 April 1999][Continued

There is no equivalent in the private sector to the NHS second stage of the patient complaints procedures, known as the independent review procedure^{3,4}. The same applies to the third stage, regulated by the Health Service Commissioner (the Ombudsman) who has no jurisdiction outside the NHS.

The NHS complaints procedure will be three-years-old on 31 March 1999 and is currently under review. The independent review procedure has been criticised by patients' groups and doctors as it lacks a real sanction. Some panels have little insight into the dynamics of clinical practice and we have had experience of unworkable and unreasonable recommendations.

CONCLUSION

The local resolution part of the procedure has merit. While independent review succeeds in its prime purpose of giving complainants a full explanation, it is not intended as a regulatory mechanism and there may be little merit in introducing similar procedures outside the NHS.

RECOMMENDATION

We have reservations about the "naming and shaming" policy currently used by the Ombudsman in a couple of cases. However, his role could be extended so that he becomes a national and independent assessment of patients' complaints. As the Ombudsman's report proved recently, when it highlighted failures in communication as a key problem, area, it should be possible to build up a picture of some common areas of difficulty and to use this information to manage risks and ensure patient safety.

Private Dental Complaints

In the UK at present, there is no universal mechanism for independent investigation of complaints about private dental care. This is considered unsatisfactory by patient representative groups, by the General Dental Council (GDC), and by the BDA (British Dental Association). The GDC and BDA have attempted to frame a private dental complaints scheme, but so far without result. The lack of progress may be related to the likely administrative cost. It is also not clear whether it is appropriate for either the GDC or BDA to administer such a scheme, given that the GDC's prime role is to protect patients, and the BDA's prime role is to protect the interests of dentists. Revisions to the Dentist's Act will be needed if the GDC is to administer a compulsory private patient complaints scheme.

Private dental care falls into four categories, with differing avenues for the investigation of complaints:

1. *Wholly private care*

No third party funding is involved, and the fees are agreed between the dentist and patient. A patient who wishes to complain about treatment has recourse to the dentist, civil litigation, and the GDC.

2. *Partly Private Treatment*

Under the NHS (General Dental Services) Regulations, subject to certain conditions, the dentist and patient may agree that some of the necessary treatment can be provided under private contract, with the remainder of the treatment being provided under NHS (GDS) arrangements. Patients may complain to the health authority only about the NHS component of the treatment, and are otherwise in the same position as patients treated wholly privately.

3. *Private Capitation Schemes*

These schemes have expanded greatly in the last ten years. Denplan is the oldest and largest such scheme, and claims to have registered 877,832 patients as of 22 December 1998. Denplan is now a wholly owned subsidiary of PPP Healthcare. Under the scheme the patient pays a monthly capitation fee, mutually agreed with the dentist, and for this fee receives all routine dental care. Orthodontics is excluded, and any laboratory items, such as crowns, bridges or dentures, have to be paid for separately (the patient pays the laboratory bill). Denplan collects the monthly payments, and makes its money by taking a commission, and by having a substantial sum in its bank account at any one time. In turn it provides certain benefits and services for its participating dentists and patients, including insurance against dental trauma and emergencies, general marketing and sales activity, and support for participating practices. However, the contract is between the dentist and patient, with Denplan essentially an administrator.

Denplan and the other private capitation schemes, which also include BUPA, seek to set quality standards, both clinical and administrative. These include the handling of complaints. Denplan, for example, has a well-established system for investigating and resolving patient complaints, including conciliation, mediation, and

29 April 1999][Continued

legally binding arbitration. The rules of Denplan allow patients to demand legally binding arbitration, and the participating dentist is obliged to co-operate. The arbitration scheme is administered by the Institute of Arbitrators, and there is at least one dentally qualified arbitrator. Denlan receives approximately 25 new complaints per month from its 877,000 registered patients.

Denplan's professional review committee can decide to remove a dentist's name from the list of participating practitioners if that dentist fails to provide high quality care within the rules of the scheme.

4. *Private Insurance Schemes*

Treatment is basically restricted to dento-alveolar surgery provided by consultant oral and maxillofacial surgeons, and others recognised by the private insurance schemes, such as BUPA, WPA, PPP. Although there is a degree of managed healthcare, and fees are controlled by the insurance companies, we have no experience of these schemes as formal mechanisms for investigating and resolving complaints about dental treatment.

Dental Bodies Corporate

In 1998 there was an explosion of activity in the Dental Bodies Corporate, that is the remaining 27 limited companies permitted to carry on the business of dentistry, following the 1956 Dentists Act. Several of the Bodies Corporate are expanding rapidly. There is no restriction on the number of practices which may be owned, or the number of dentists who may be employed, by a single Body Corporate.

Many of the Dental Bodies Corporate are trying to impose their own quality standards, and are clearly interested in the satisfactory resolution of complaints, as part of overall customer service. There is now an Association of Corporate Dental Practices, and attached is a copy of the Association's Declaration of Principles.

RECOMMENDATION

Of the 19,800 GDPs contracted to the NHS most, if not all, have some element of private practice. The committee may wish to consider the private dental complaints procedures in more detail as clearly they demonstrate that it is possible to regulate practitioners in private practice and to give patients alternative means of dispute resolution.

Health Insurance Companies

Companies such as BUPA run their own patient complaint procedures, essentially along the same lines as the NHS first stage patient complaint (or Local Resolution) procedure.

The recognition, and the withdrawal of recognition, of an individual doctor for the purposes of payment is at the sole discretion of the individual company.

Recognition is often granted on the basis that the doctor holds an appointment, or has held an appointment, as a consultant in the NHS.

Doctors who have recognition withdrawn arbitrarily by health insurance companies, seldom, if ever, have grounds to challenge the decision through the civil courts.

CONCLUSION

Regulation through admission rights to private hospitals and recognition for payment by insurance companies may apply to most, but not to all doctors in the private sector. Currently these regulatory mechanisms cannot be relied on to protect the public.

NHS disciplinary procedures

Mixed lessons can be learnt from disciplinary proceedings within the NHS.

Many NHS trusts have introduced a variation on the HC(90)9 procedures to deal with allegations of professional misconduct. (Personal misconduct is dealt with differently.) In The MDU's experience, very few NHS trusts implement their professional misconduct disciplinary procedures in a competent manner. This may be because no individual NHS trust has enough cases for its management to build up the necessary expertise, and it can lead to a waste of taxpayers' money.

29 April 1999]

[Continued]

CONCLUSION

The NHS disciplinary procedures cannot be transferred into the private sector as no blanket, contractual arrangements exist.

The Civil Courts

In the MDU's experience medical negligence claims against doctors are rising at 15 per cent per year in frequency and cost. In the UK this includes general practitioners and private practitioners. As there is no data centrally available, it is difficult to assess how this compares with litigation in the NHS. Currently it is possible that there is less litigation in the private sector because patients are less likely to qualify for legal aid. However, changes in the legal aid system, the introduction of conditional fees, and changes in the civil justice system now in the pipeline, might alter the number of successful claims made by patients treated outside the NHS.

CONCLUSION

Medical negligence litigation is a blunt and inefficient instrument for regulating the medical profession. In addition to the sometimes considerable cost, it can be a slow and stressful process for both parties. Some patients clearly need financial compensation because of injuries they have suffered as a result of negligence. However, those who represent patients say the single most common reason for initiating medical negligence claims is that they are upset by the doctor's attitude and feel litigation is the only way to get an adequate explanation for what has gone wrong. Many prospective plaintiffs also need reassurance that steps are being taken to make sure no other patient suffers in the same way. These concerns are more appropriately addressed through a complaints procedure.

The Criminal Courts

For humans, there is no direct equivalent to the Veterinary Surgeons Act 1966 and the Animals (Scientific Procedures) Act 1986 which specify which surgical procedures may be carried out on animals and by whom. Some specific procedures on humans are regulated by statutory law, such as abortion, infertility treatment and female circumcision.

Allegations of crime against doctors are rare, and the criminal courts play a limited role in regulating the medical profession.

F. SUMMARY

The effective regulation of the clinical performance of doctors working outside the NHS is achievable largely through the GMC and, possibly through an extension of the Ombudsman's role, with the help of the medical royal colleges and faculties where appropriate.

The GMC has already done a lot to improve the effectiveness of its procedures, but further radical reforms are needed, such as the introduction of a more proactive approach. It does not have enough money or manpower to do this and its level and source of funding may need urgent review.

January 1999

REFERENCES:

1. Coiera, E., *The Internet's challenge to health care provision*, Brit.Med.J., 1996, 312, 3.
2. *Good Medical Practice*, The General Medical Council, July 1998.
3. *Practice-based Complaints Procedures—Guidance for General Practices*, NHS Executive, January 1996.
4. *Complaints Listening . . . Acting . . . Improving*, NHS Executive, March 1996.
5. *Maintaining Good Medical Practice*, The General Medical Council, July 1998.
6. *Suspension of Consultants*, Hospital Doctor, 29 October 1998.
7. "All doctors to be given performance checks", The Sunday Telegraph, front page, 3 January 1999.
8. Hawkins, C and Paterson, I. *Medico-legal audit in the West Midlands region: Analysis of 100 Cases*, Brit. Med. J. 1987; 295: 1533–1536.
9. *Complaints & disciplinary procedures*, Healthcall Duty Doctor Services, British Medical Association, 1998.

29 April 1999]

[Continued

*Additional reading**The MDU/Pulse guide to the complaints procedure*, The Medical Defence Union Ltd. London 1996.Green SA & Price, J. *A review of general practice complaints*. JMDU 14 June 1998: 11.

© The MDU 1999

Annex**ASSOCIATION OF CORPORATE DENTAL PRACTICES—DECLARATION OF PRINCIPLES**

At the inaugural meeting of ACDP members present have discussed and agreed the following principles and aims of corporate bodies in general. Whilst it is recognised that corporate bodies have differing strategies and styles, these principles incorporate a shared vision for the whole of dentistry in this country.

1. A desire to see the level of investment in practices and in dentistry as a whole increased significantly.
2. A commitment to developing in-house quality control procedures.
3. Aim for a professionally accepted standard of practice, covering clinical, administrative and customer care.
4. A commitment to develop a code of practice.
5. A commitment to advance clinical practice and career pathways for the whole dental team.
6. Remuneration of dentists in line with market conditions.
7. All dentists to have informed and mutually agreed contracts.
8. All practices to run in a commercially viable manner, using sound business knowledge to make dentistry more efficient and profitable.
9. A commitment to reinvest into practice development and people development.
10. A fundamental commitment to clinical freedom in diagnosis and treatment and a desire to guide dentists to maximise their clinical ability.
11. A recognition that dentistry is and will remain a profession based on service to the patient.
12. A desire to have transparency in activities, welcoming involvement and advice from all professional and regulatory bodies.

*November 1998***Extract from a letter from the Chairman of the Private Practice Forum to the Clerk of the Committee****PRIVATE MEDICINE (PM 68)**

There is need for . . . guidance framework to complement in private practice the framework for quality standards in the NHS which have recently been set out in the White Paper "A First Class Service: Quality in the New NHS". The Forum is also conscious of the need to ensure that arrangements for private practice will conform with the requirements of the National Institute for Clinical Excellence and the Commission for Health Improvement. We hope to work closely with these and other relevant bodies so that the standards for private practice will be shown to be at least as high as those which will be set for the NHS. At present the arrangements for Clinical Governance in private wings of NHS Trust Hospitals seem unclear.

A working party of the Forum is currently developing detailed proposals for a complaints procedure in private practice and this document will be widely circulated for consultation in due course.

*2 February 1999***Memorandum by Private Practice Forum****PRINCIPLES FOR A PRIVATE MEDICINE CLINICAL QUALITY FRAMEWORK (PM 68A)**

For each independent hospital, clinic or pay-bed unit:

- The Hospital General Manager is accountable overall for quality and risk management;
- There will be a Medical Advisory Committee (MAC) which should include representation of each specialty working at the hospital;
- The General Manager, MAC and designated consultant (see below) should agree a documented clinical governance framework which will provide the constitutional basis for developing a clinical quality strategy (see below);

29 April 1999]

[Continued]

- A designated consultant (often the MAC Chairman) will take responsibility for delivering (with the support of the other clinical professional “heads”), reporting on and evaluating the documented clinical quality strategy, involving and covering all clinical staff and departments;
- There must be 24-hour on site RMO cover for in-patients, all RMOs having advanced life support training and certification and relevant clinical experience. Free-standing day-case centres should have appropriate medical cover in working hours, with arrangements to deal with out of hours emergencies;
- Where present, and ITU and/or HDU (as defined using nationally accepted criteria) has relevant on-site specialist medical cover when in use, under the supervision of an appropriate intensivist/anaesthetist;
- There must be a properly constituted and administered clinical complaints procedure;
- There must be maintenance of adequate clinical records (including medical component);
- Current organisational quality standards, externally verified will be held (eg HQS, ISO, EQM or HAP).

Designated Consultant (working with the MAC)

Will take responsibility to:

- Develop and ensure delivery and evaluation of Clinical Quality Strategy to include:
 - clinical risk management programme;
 - clinical audit;
 - measurement of clinical outcomes;
 - formal procedures for the review of clinical competence;
 - clinical education, training and professional development;
 - prompt analysis of untoward clinical incidents and clinical complaints;
 - integration with wider quality programmes within the hospital;
 - annual report on clinical quality.
- Ensure maintenance of agreed standards in relation to proper clinical notes and consent forms, and ethical committee approval for research studies;
- Liaise with counterparts in other local hospital/units, particularly where there may be concern about the activities of a consultant in relation to patient safety or professional conduct. Where there is evidence that patient safety may be threatened, there is a duty to inform local hospitals/units (preferably doctor to doctor) and medical directors of major insurers. Reciprocal arrangements should also apply.

Medical Advisory Committee (and Speciality Groups)

Advise the Hospital General Manager on practice privileges (including scope), having taken specialty specific advice and/or having followed formal clinical competence review procedures as appropriate.

Regular review of clinical information, including:

- all deaths
- unplanned re-admissions, re-operations and transfers to other hospitals/units
- infection control data
- unexpectedly long lengths of stay
- out of licence use of drugs
- untoward incidents

Support development of local good practice standards (clinical guidelines) and multi-disciplinary care pathways—preferably based on national/evidence based guidelines.

Agree priorities and protocols for clinical audit and outcome measurement, support and facilitate regular clinical audit in each speciality and disseminate written records of such audit within each speciality and to the designated consultant.

29 April 1999]

[Continued

Each Doctor

Medical practice privileges contingent on:

- NHS consultant status (or equivalent)
- adherence to GMC or GDC good practice guidelines
- evidence of Hepatitis B immune status as advised by Department of Health
- maintenance of appropriate professional indemnity at all times
- adherence to hospital health and safety policies
- participation in hospital complaints procedure
- health status appropriate for clinical practice

Also required:

- active participation in clinical audit—including relevant National Confidential Enquiries
- participation in continuous professional development
- three year review of professional development plans

All patients undergoing procedures to give valid, informed consent, following discussion with clinician conducting the procedure, in accordance with agreed hospital policy.

Insurers

Except for reasons of urgency, clinical complexity and/or geographical access (for individual patients) insurers will seek to avoid contracting with hospitals failing to meet at least the standards set out in the Framework from 1 January 2000.

Timetable

Uncompleted stages of Framework to be implemented from 1 February 1999.

Target for full implementation—1 January 2000.

January 1999

Examination of Witnesses

SIR DONALD IRVINE, President, and MISS ISABEL NISBET, Director of Fitness to Practise, General Medical Council, DR GEOFFREY MITCHELL, Chairman, Independent Doctors Forum, DR CHRISTINE TOMKINS, Professional Services Director and MR RUPERT HOPPENBROUWERS, Head, Dental Defence Union, Medical Defence Union and DR JEFFREY JAY, Chairman, Private Practice Forum of the Academy of Medical Royal Colleges were examined.

Chairman

842. Can I welcome our second group of witnesses, and sincerely apologise for the slight delay in starting the second part of the session. I think most of you were here for the earlier session, so you are broadly aware of the areas that we are touching upon. Can I begin by thanking you for your written submissions to this inquiry, and could I ask you each, briefly, to introduce yourselves to the Committee, starting with Dr Jay?

(Dr Jay) Dr Geoffrey Jay. I am a full-time consultant NHS ophthalmologist, from Glasgow, and Chairman of the Private Practice Forum.

(Mr Hoppenbrouwers) Rupert Hoppenbrouwers. I am Head of the Dental Division of the MDU, the Medical Defence Union. I am a former general dental practitioner.

(Dr Tomkins) Christine Tomkins. I am Professional Services Director of the MDU. I joined the MDU in 1985 from the NHS, where I was an ophthalmologist.

(Dr Mitchell) Geoffrey Mitchell. I am Chairman of the Independent Doctors Forum. I have been in full-time, private general medical practice for 30 years; before that, I was in the Air Force, working as a physician. I spent four years in charge of the RAF Artificial Kidney Unit at Halton. And I am here hoping to put in a word for the private general practice.

(Sir Donald Irvine) I am Donald Irvine. I am the President of the General Medical Council.

(Miss Nisbet) I am Isabel Nisbet. I am the Director of Fitness to Practise at the General Medical Council, and for four years before that I was the Deputy Health Service Ombudsman.

843. Thank you. Can I begin by asking one or two questions of our witnesses from the GMC. You heard the discussions earlier on about the tension that may be there between the pressures of the market and professional standards, and you, in your evidence, state, right at the outset, and I quote: "The GMC makes no distinction between doctors in the public and private sectors." Now I am interested in this particular point, in respect of this earlier

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Chairman Cont]

discussion we had about the possible conflict between the business pressures and the professional standards on an individual doctor. I think you may be aware that last week we spent some considerable time talking about the question of cosmetic surgery and the appropriateness of certain interventions in particular situations, where people may be enticed into undergoing operations that are of very dubious value. My concern, in that session, was to establish where the safeguards are, in respect of the patient, and when I was putting to some of the private sector witnesses this concern they were saying this is entirely a matter for the GMC. Now I would like to know where in that kind of scenario you fit in, because it does concern me that certainly the evidence that we have before us, from a number of organisations, does suggest there are some clear problems there, in this tension between the business side and the clinical standards, the professional standards, in any particular case. Sir Donald, do you want to respond to that general point?

(*Sir Donald Irvine*) Perhaps if I could make just two or three general points first, to put this in context. The Council's business extends to doctors wherever they are, and, as you point out, we make no distinction about who they are employed by, or whether they are employed or not; it is the only piece of regulation that actually does cover a doctor wherever they practise. The second point is that life has changed since we set out in 1995 and reinforced in 1998 what the duties and responsibilities of a doctor are, and that process of change is going on as people discover, doctors in particular, that the words mean what they say and are backed up by our Fitness to Practise procedures and our willingness to act against doctors if they are severely in breach. The third point is that, in terms of both competence and conduct, there is a huge change to come, probably the biggest since the 1858 Act, when we introduce revalidation in three years' time; revalidation is just a shorthand way of saying that, in future, every doctor, wherever they are, will have to show that they are up to the mark and conducting themselves properly, and put that evidence down. And it is our business, as the holder of the register, to be able to satisfy you and the wider public, in due course, that that is working properly. So, to your point. We are acutely aware of that tension, which is why, in Good Medical Practice, I can give you the page reference, 16, and it is paragraphs 50-52, we made explicit reference to that tension. We have no neat prescription for making the tension go away, but we have set out quite clearly that a doctor has to have an open and robust relationship with the patient, and the patient has to know about any financial arrangements that the doctor may have with any institution with whom he is working, using, or otherwise in contact. And we have also made explicit reference, lastly, to the fact that there are conflicts of interest at times where it would be advisable for a doctor to resolve that by not practising in situations where there is a financial interest as well.

844. Do you have any involvement, where there may be, you talked about bad practice, perhaps the word I would use is whether a practice is appropriate, and I accept the fact there are some very significant debates between medical practitioners on what is the

appropriate course of treatment in any similar set of circumstances, there are differences, there are marked differences, in some instances, but where you may get representations relating to the appropriateness of a particular practice? What is the role of a GMC in such a situation? Say, I go to a plastic surgeon and I feel that I have become disfigured as a consequence of an intervention that was very dubious from the outset, that that intervention that you may look at as an individual doctor and say, well, you would not do that in the circumstances, how would you handle a situation such as that?

(*Sir Donald Irvine*) Again, I would go back to our function, which is actually to set the general framework and the general principles, in Good Medical Practice, and that includes the matter of appropriateness. We expect a doctor who is doing anything to know what they are doing and to be able to perform to an appropriate standard. We also expect, and explicitly state, that doctors should not do that with which they are not equipped, and that if they stray into that area then they are vulnerable. So our business is to set that general framework and make that clear, and where there are breaches to act on those. That actually represents a very significant change, because those remarks are addressed to the whole practising profession; it is a significant move away from a GMC which used to simply concern itself with dysfunctional practice and act on complaints, it is addressed proactively. Your words earlier were about prevention, our business is prevention here. When it comes down to the specifics of what is good plastic surgery, or what is good psychiatry, that is where the role of the Royal Colleges, as standard-setters in their field, comes in, and, within that, of course, you have also got sub-groups of expertise now in many of the specialist societies and associations. So we look to them for information about the particular of that kind, but the underpinning and the statutory framework for acting rests with the Council.

845. You were present when the BMA were arguing very strongly for an enhanced role of the MACs within private hospitals; you heard the concerns that I expressed, I think, or certainly Howard Stoate followed up with some questions, over the way in which the MAC may not be the appropriate body to deal with a particular problem, in that there are vested interests within that body, or there could be vested interests within that body, that might prevent appropriate safeguards to an individual patient. What are your views on the BMA model?

(*Sir Donald Irvine*) I think I could answer best this way. I think we are looking, in this country, for a new approach to medical regulation, which combines the matters to do with the personal conduct and performance of a doctor with the managerial or institutional arrangements, but, of course, we have heard very little in this about the patient's input to this. And I think our view is that we are working towards, with Government and others, a system that will combine these, and really the art, if you like, the task, in the next two or three years, is to find the best means of docking these pieces, so that each piece does its job properly. That introduces the concept of

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Chairman Cont]

checks and balances, which we think is important, and there is work to be done there, for instance, between the work of the Commission on Health Improvement, if I can use the example of the Health Service for a minute, and our own concern with the individual practitioner. And we have some practical examples now where we are investigating complaints, matters to do with the institution arise, and we are telling people we are in a capacity to do something about that, and I can see the process working in the opposite way as well. So I think we are feeling a way towards that combination. Now, it does seem to us that a comparable mechanism is needed in the private sector, and to that end we have opened discussions with the insurers and the key providers about what the institutional framework might look like. I am conscious that it will not answer all questions, in particular, where you have private practitioners who do not belong or work in any institution at all; but you move this by a process of exception. At the end of the day, where there is no institutional framework, we will ask doctors, it will be the doctors' duty, to provide us with the evidence that they are up to the mark and fit to practise in their chosen field, they will be required to do that.

Mr Gunnell

846. Why, at the moment, is it not a requirement for doctors practising in the private sector to be on a Specialist Register; it is not a requirement, is it?

(*Sir Donald Irvine*) That is correct.

847. Why not?

(*Sir Donald Irvine*) The Specialist Register was introduced by Parliament to deal with a particular matter to do with the employment of doctors in the National Health Service and to deal with a particular matter related to European legislation. Our view is that the Specialist Register is not fit for the purpose that it ought to have, which is to be a clear descriptor of a doctor's field of practice, of specialist practice, wherever they are. Also, like the current Medical Register, it simply tells you who has qualified, who has achieved a specialist qualification, and it tells you nothing about the doctor's continuing fitness to practise. Aware of that, and in particular after the aftermath of the Bristol hearing, I wrote to the Academy of Royal Colleges and to the BMA simply to say "We can't unknow what we know, this is the fact of the matter, the Registers aren't doing what the public expects them to do, there is a gap here," it is, incidentally, an international gap, it is not peculiar to Britain, "and that something has to be done about it." And the doing something about it started with our proposals to change specialist registration, through revalidation, so that it meant a doctor's performance; actually, that was rather a narrow view itself, which is why, in February, the GMC decided to go the whole hog and apply the principle of revalidation to the General Register. But I would not like you to believe, I would not like to mislead you in believing that, therefore, our eye has gone off the Specialist Register; it has not. We have to see how these two pieces come together so that, from a patient's point of view, or an employer's point of

view, the Register means the best possible thing it can about a doctor's fitness to practise, up-to-date, at that point in time.

848. And, presumably, would say, in a way, what he is fit to practise; it would be confusing if you said someone was on a Specialist Register and you wanted an ophthalmologist and you got a gynaecologist instead. So you really need a Specialist Register which indicates which areas the specialist is able to specialise in?

(*Sir Donald Irvine*) The decision about the Specialist Register was drawn fairly broadly, when it was introduced, and the reasoning for that was quite sound, it indicated the broad area of practice within which the doctor would work, psychiatry, medicine, etc. There is a problem with trying to refine the descriptor further; taken to its absurd point, you would have a Specialist Register which indicated the operation in which a particular person operated. And, of course, if you make that restrictive, as the licensure is, then you run into all sorts of operational and practical and legal problems, which is why, in 1975, the Merrison Committee advised against that, and those principles, we think, still hold good today. I think the key thing that we have learned is that overreliance on the descriptor alone, not underpinned by an up-to-date, working knowledge of the doctor's skill in the practice he, or she, claims to be practising in, can lead you off the boil, it leads to a weaker system. We are back to revalidation again; revalidation is about evidence of performance.

849. Would there also be a difficulty perhaps with some private practices, certainly, we have drawn the distinction between the mainstream providers and some of the less reputable ones, and would there not be a difficulty with some that they might advertise they had somebody on a Specialist Register, they then wish to use that person for a field quite other than his specialism?

(*Sir Donald Irvine*) It is all to do with the honesty and truthfulness of practice. If a practitioner holds himself, or herself, out to be practising in a field which is actually outwith their competence, and if they have misled, by the nature of their specialisation, if they are operating outside of their field, well then they are at risk of GMC action, on conduct.

850. Yes, you would take action, if you found an employing organisation specifically using advertisements of that misleading sort; your action would be against the individual person you have registered?

(*Sir Donald Irvine*) Yes, absolutely. We have been into this area before. As the point was made earlier, we have no jurisdiction over institutions at all, but doctors who are either working for or engaged with institutions and who knowingly enter into relationships which are prejudicial are at risk of GMC action.

Chairman

851. Could I ask, on that, obviously, it takes us on to the issue we touched on in detail last week, of advertisements, particularly for cosmetic surgery, cosmetic clinics, interventions, do you have any

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Chairman Cont]

examples whereby you have taken action against doctors? I appreciate you may wish to follow this up with a letter, I am putting you on the spot, but this is a very important area, from our point of view, because, clearly, we have had a good deal of evidence of concern among the public about the way in which people are very badly misled as to the nature of the qualifications of people who will be treating them, and the nature of the treatments, perhaps. So have you taken action in those areas, have you any evidence that you can give us on that?

(*Sir Donald Irvine*) I would like to take up your offer of a supplementary, so that we can give you as accurate a picture as possible. I can say that, over the years, the question of advertising and information has caused more questions, complaints, than almost anything else, and we have found that extraordinarily difficult to translate into a form in which you could actually bring an action; an action requires evidence, testable, provable, the whole gamut of a formal, legal procedure. And, in a sense, that was why we simplified our guidance and actually abandoned the whole business of advertising at the time of our discussions with the Monopolies and Mergers Commission. The GMC stance then and now is that the provision of good information to the public about what doctors do is in the public interest, that it is a good thing to do. We very positively went down that road; we simplified our guidance to the point of simply noting that doctors had to abide by the general standards of advertising required by the authority, decency, honesty, truthfulness, etc. And it remains the case that if there are any serious departures from that we will act in that case, but I am not aware of the fact that we have brought such a case recently; it is not for the want of looking, it is the difficulty, it is the evidential difficulty involved. But, I think, if I could make just one last point, we have also concluded that, from a public safety, public protection point of view, an overfocus on that will draw the eye away from the main point, from a patient's point of view; it is, whatever the doctor is doing, and whatever the adverts say, can the doctor do what he, or she, is supposed to be doing properly, appropriately, is the behaviour at the bedside, in the operating theatre, as it is supposed to be. That is where the evidence of revalidation will come into its full power and force.

(*Miss Nisbet*) Chairman, if I could just add that there have been some cases in the past of conduct cases against GPs who ran slimming clinics. And in one example, in 1993, there was a doctor who was erased, with immediate suspension; it was both that his treatment was inappropriate, in fact the Committee could never discover what some of the substances were that he was injecting into people, but also they expressed explicit criticism of his advertising, both for the reasons the President has alluded to but also, going back to earlier discussion, because he was advertising appropriately a "specialist service" direct to members of the public, and this was bound, in the view of the Committee, to increase the risk of patients seeking treatment of a specialised nature inappropriately from him, without first consulting and being referred by their own GP. So all these concerns were brought together in that case, and it is not unique.

852. If you do have any further information in that area, we will be very grateful to hear from you?

(*Miss Nisbet*) Yes, we will.

(*Sir Donald Irvine*) Yes, we will look at that for you.

Chairman: Thank you very much.

Mr Walter

853. If we stick with the GMC for a moment, actually you make no reference to external regulatory mechanisms in your evidence to us, and place a great deal of faith in registration and revalidation. I am particularly concerned, but I want to widen this out in a minute, about how effective that is in the smaller clinics, and so on. We heard evidence last week of a consultant dermatologist who gave a clinic a blanket approval, that he could say that, any patient who walked in, he had referred them. I do not have the name of that man, but it came from a very good source. Now, in a small institution, how effective do you think your revalidation process will be?

(*Sir Donald Irvine*) If you feel that I have overemphasised the personal element then I have misled you. I did say that we were looking for a system which combined the managerial, institutional, with the personal, and we do believe that the two parts are essential. We would agree with you, also, that the principle of external review is fundamental to any good regulation, which is why it has been built into our own system for revalidation and why we would expect it to be there, and the Government's proposals for the Commission on Health Improvement and the comparable arrangements in Scotland to be there, too. So this principle of external review is very important. But I think I would also agree with the sentiment that you are expressing, that in larger and better got-together institutions, clearly, the arrangements for governance, if you like, are likely to be more robust and rigorous than they are in some of the smaller institutions. My own position, and I think the Council would agree with me here, is that the principle of institutional, external review is one which ought to apply wherever health care is provided, and, in that sense, the example of the Joint Commission and the other external institutional regulators in the United States has given a lot of very valuable operational experience of just what can be done, and how. But I think I was drawing the limits of dependence on smaller institutions which might have different agenda, to point out that, whatever else, a consistent standard of practice from the individual practitioner will be expected by us, in an explicit way, in future, in a way it is not now, and that that itself should be a major step forward. Ideally, you would have both an institutional input and the input about the individual practitioner.

854. If I can just look at the institutional input and the regulation of the institution, and perhaps if you were here for the previous session and my questioning of the RCN and BMA was that we should have a common framework, maybe with the standards laid down by CHI, or whatever, and we got into questions about Regional Care Commissions,

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Mr Walter Cont]

and so on; but would you see a common, external framework across both the public and private sectors, would you welcome that?

(Sir Donald Irvine) The principle that standards of care, however they are provided, and by whom, patients are entitled to expect a good standard of care, a consistency of care, whatever the sector; we think that that is our starting-point.

Chairman

855. But should the same framework cover both sectors, that is the issue?

(Sir Donald Irvine) We have not got a position on that; you can argue that both ways.

856. I am not arguing it, I am asking you what your thoughts are?

(Sir Donald Irvine) I am conscious of the fact that the Commission for Health Improvement is about England and that we have already got a separate mechanism for Scotland, and so I do not think I want to get too drawn into what could be quite a politically contentious matter. I will make just two further observations. Whatever constitutional route is taken, it needs to be based on a sound methodology and use sound systems and sound arrangements, and use well-trained people, it is all that gamut that is absolutely essential, and that, if you are going to do that consistently, would argue for a single, rather than a fragmented, system. That has actually been the pattern in the United States; but the key to success, I suspect, will turn less on whether you have one or two or three agencies than the thoroughness and professionalism with which they carry out their job, and, I should add, the degree of independence that they are able to exercise over providers of any kind, including the National Health Service, in the ultimate public and patient interest.

Audrey Wise

857. We have received quite a bit of evidence, this is still to the GMC, that people encountering difficulties with an independent hospital, in particular, complain to the hospital and then are told that that organisation has no responsibility for the consultants to whom admitting rights have been granted, and there seems to be considerable opportunity for passing the buck back and forth. Do you think that doctors can be regulated adequately without reference to the organisations within which they practise?

(Sir Donald Irvine) No, I do not. I think it is a symbiotic relationship, and it is back to my answer to you, Sir, which is why we have to get this fit between governance and individual regulation right. I do believe, also, and I have had this conversation quite recently with the Secretary of State, that whether patients are in the National Health Service or going privately it is for many people quite confusing as to how to find your way through this, and that applies to people using our service, too. And we are keen, and my understanding is that he is, too, that we look to see how we so simplify and reorganise the flow of complaints that they are as user-friendly as possible and that the kind of situation you are describing should ideally not exist, but at least it becomes a darn

sight less frequent than it does now. I think, if we could start with the patient and work through the institutions, rather than asking how does each institution handle this, we might come up with something better than we have got; we certainly think that should happen.

858. Thank you. Still sticking with organisations but a different aspect, and one which I explored with the BMA witness, and that is the relationships with insurers, in particular, and with special reference to the so-called partnership arrangements, especially exemplified by what BUPA has launched. I know that you, in your evidence, the GMC has no jurisdiction over health care organisations, and, presumably, obviously, over insurers, no jurisdiction, that is a carefully chosen word, I rather think; later on in your evidence you say you have opened discussions with the major private health care providers and insurers about ways in which practice can be improved. So, obviously, you can have a relationship, although you do not have jurisdiction, you cannot say to BUPA "You're going to leave the market." Now we had quite an exchange on this, because the BMA witness emphasised the individual aspects of the GMC's role, but, again, in your evidence, two of your four functions, as listed by you, are general, one is fostering good medical practice, and one is promoting high standards in medical education, they are general, they are not just picking up the casualties, or finding the bad apple. Do you think that you may possibly, therefore, have a role in setting a general standard, or requirement, or some such, in relation to doctors putting themselves in a position *vis-à-vis* insurers, which could call into question the matter of conflict of interest, or motivation?

(Sir Donald Irvine) In a nutshell, yes. I think I can explain how the relationship might develop best if you would permit me to refer to the relationship with the National Health Service, where a comparable situation is arising. As the GMC, we have no jurisdiction over health authorities and Trusts, but we are into a far more active dialogue than we have ever been before about what our expectation is of them, in their arrangements for governance, about doctors whom they employ, or contract with, or in other ways use the National Health Service. And, quite explicitly, to try to get it clear that the principles of good medical practice, wherever they employ doctors, are those that we would expect management to be using, expecting, underpinning, with its governance arrangements. That is quite new, this is something that is quite new for Health Service management, and it is new for the Council; we are being quite assertive about that. In the last two or three months, I must have met about 300 Chairmen in the Health Service, discussing their responsibilities in governance for individual practitioners. In our preliminary meetings with the private providers and insurers, we are taking exactly the same theme; we have no jurisdiction, but we can indicate quite explicitly the kind of people we would expect them to be supporting financially, or allowing to use their facilities, that these are the standards that are expected and that these are the standards against which a doctor will be judged, if anything goes wrong. So if I were an insurer or a provider I would

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Audrey Wise Cont]

want to satisfy myself that the doctor was complying with the GMC's requirements, and, in future, was also revalidated; that would be an essential part of it. And this, in a sense, is where the two systems, the principles, come together, there is a unifying approach to this.

859. That is very interesting and very encouraging, but have you formulated any view on arrangements, such as the BUPA Partnership, which can involve doctors getting bonuses if they meet certain targets for discharge, or whatever, or similar developments?

(*Sir Donald Irvine*) No, we have not, and that is not our business, but it would become our business if matters of financial conflict arose. It is our business to set out quite clearly what the conduct of a doctor in relation to financial interests is about, and I take you back to page 16 of *Good Medical Practice*, the principles are all very, very clear. I think what we often find is that people do not either understand these or use these, and this is why the Council is in such a different and strongly determined mode, to make sure that each of the principles is understood and practised by every doctor.

860. To the Medical Defence Union, first of all, and then it will be back to the GMC. What has the impact been of the extension of the Ombudsman's role in the field of clinical complaints in the NHS?

(*Dr Tomkins*) The Ombudsman has only been involved in listening to clinical complaints since 1996, so it is still fairly early days, but, in our limited experience, because of the length of the procedure, we have found that the Ombudsman has taken a very active interest in clinical complaints and that his independent overview of the complaint has been helpful to both the doctor and the patient, and I think it is particularly helpful that he has a view of complaints in both the primary and the secondary care health sectors.

861. In your evidence, you say, with regard to the role of the Ombudsman, however, his role could be extended so that he becomes a national and independent assessor of patients' complaints, and I am taking that to mean that you want his role extended to the private sector as well, so that it is all complaints. Is that an accurate picture?

(*Dr Tomkins*) Yes, it is. I think one of the difficulties in the private sector is that it is confusing and difficult for patients to know to whom they should complain and how they should complain, and there are models in other jurisdictions, such as New Zealand, where the Health and Disability Commissioner takes complaints right across the public sector and the private sector, and that scheme has been going since 1996 and seems to be well received by both doctors and patients. If it would be helpful, I could provide some information about the New Zealand scheme, including some information from the Health and Disability Commissioner herself about investigations she has made into private sector complaints.

862. I am sure we would welcome that. Could I ask, in particular, though, who would pay? I can see the concept of an Ombudsman for the public services, and publicly-funded, but if it goes into the private sector how should that aspect be funded, who should pay?

(*Dr Tomkins*) I think that the question of payment, as far as payment for the Ombudsman's services, is not something that the Medical Defence Union has considered; as far as paying for assisting the doctor, we would expect to assist the doctor, as part of his benefits of membership.

863. No, I meant the paying for the provision of the service, the funding of it, I was not thinking of individuals exactly but the funding of the service; it does not arise with the Ombudsman, because it is publicly funded, it is public complaints, but if it were to chase up bad practice in the private sector should that still be publicly funded?

(*Dr Tomkins*) I think one might look at models in other countries to see how they fund this sort of thing, and, as I recollect, in the New Zealand system, it is funded, when the complaint is in the private sector, by a payment by the patient who wants to bring the complaint and by the practitioner.

864. I see. Could I turn to Miss Nisbet, in particular, more in your previous role, I think, than your present one, because you have got direct experience here. Do you have any views about whether the role of the Ombudsman should be extended to cover the private sector?

(*Miss Nisbet*) Thank you. Just to clarify which hat I am wearing, if you like. Wearing my GMC hat, I think the main point is that the principle of having external redress available for patients of the private sector is a very important principle; how it actually works out, in practice, I would have thought, would be a less important matter for the GMC. Now, if I may revert to speak personally and from my own experience with the Ombudsman, there have been attempts before to try to extend this principle of extending the Health Service Ombudsman into the private sector, and they tended to founder along the same debate as you had with the earlier witnesses about scope, about whether you were talking about private hospitals or whether you were talking about the whole hinterland with nursing homes and then the link with residential and social care. And then particularly when they got into what are sometimes called alternative therapies they got into a terrible mess, and the attempts to propose amendments to the 1995 Health Service Commissioners Bill foundered there, and there was even discussion last year about a Private Member's Bill, which foundered in the same way. So I think the real issue, and the Ombudsman would speak for himself, is that he would want to be part of any way of improving redress for the private sector, but how you actually divide up the responsibilities is never going to be satisfactory for everybody. As the Committee may be aware, the Cabinet Office are reviewing the arrangements for public sector Ombudsmen at the moment, there is a big issue of whether there needs to be many more links between health and social services redress, for the reasons that the Royal College of Nursing was giving. And that pulls the public sector together, if you like, and then, if you try to bring medicine together, what about nursing and all these other areas; so, however you do it, it is not going to be ideal. And I think what the Ombudsman would say would be that there should be fewer of them than there are now, there are too many, but however few you have there are always going to be

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Audrey Wise Cont]

some borderlines, and they need to be able to talk to each other and work together much more efficiently, and I think that is the bottom line.

865. Fewer of whom?

(Miss Nisbet) At present, Chairman, there are large numbers of Ombudsmen, every day you look in the papers and there is a new one; some of them are voluntary Ombudsmen, if you like. And also the number of redress machineries available to patients, who often do not know what kind of service it is that is treating them, is becoming more and more bewildering. And that goes back to what the President said about every participant in this game has to work with others to try to help patients who came in at one door to find the right place. But there are many people that the GMC cannot help, because their complaint is not about a doctor but about a hospital, for example; now, in the GMC, we need to be able to help them to get onto the right avenue to pursue their complaint. And, whatever we do about the private sector, there is going to be that problem all the time.

866. You could perhaps think of it in terms of those practitioners who are in some way state registered, that would cover doctors practising privately, it would cover nurses, it would cover other Professions Allied to Medicine and the newest registration by chiropractor; that would seem to be a possible, practical solution to that. Have you given any thought to that, or the Medical Defence Union, likewise?

(Miss Nisbet) I really would have to suggest that the Ombudsman might want to reply to that. I should say that there have been various attempts to do that, and it has always been very difficult to draw the line. But I think I would go back to the principle, there should be some redress for the patient, and patients are not often very clear about what these borderlines are.

(Dr Tomkins) Again, perhaps I could go back to the New Zealand system. In fact, my recollection was wrong. When a private sector complaint is brought to the Health and Disability Commissioner there is no payment. I was thinking, in fact, of the DenPlan scheme.

Chairman

867. So there is no payment by anybody?

(Dr Tomkins) No, there is no payment by anyone. And the Health and Disability Commissioner does not make a distinction between practitioners who have a registration body and those who do not, she will take a complaint for anything to do with any aspect of health care, right through the gamut of complementary medicine, right down to people who sell potions through the newspaper. And, from the point of view of the patient, who may very well not be able to make the distinction between what is health care delivered by a registered medical practitioner, or an otherwise registered practitioner, and what is not, I think that has a simplicity which is helpful to the patient.

868. And this system is state-funded then, presumably?

(Dr Tomkins) Yes.

869. And there is no contribution from the private sector whatsoever?

(Dr Tomkins) Not that I am aware of.

Audrey Wise

870. It obviously would involve a much enlarged service. The Ombudsman, it always seems to me that, the Parliamentary Ombudsman and the Health Ombudsman, both of those roles are already pretty exacting, and I know that the reports always talk about the increased number of complaints being dealt with; but to extend it in the way that you have mentioned would multiply by many times. So I am particularly interested in having some additional information from you; thank you?

(Dr Tomkins) I will certainly provide it.

(Sir Donald Irvine) May I add just one comment on that. You may have looked at the Australian arrangements, but the patients' health commissioning arrangements there at least are worth looking at, if you are not familiar with them. But I would just like to underline, from our standpoint, Ms Nisbet's point, and mine earlier, that we think that the system can be improved for the patient, if there is better cross-connection between the different agencies to whom complaints come; at least it is one way in. It is interesting that, 17 per cent of complainants to us, there is actually no doctor's name attached to it, and we are looking, just from our own perspective, at how we can help these people, what is it, it is not within our jurisdiction, but how could you help to take this forward. There is something about it all being in boxes, and it is making the cross-connections. The onus at the moment is on the patient; it seems to be the wrong way round.

Julia Drown

871. A question for the Defence Union. I asked the BMA earlier why doctors who were suspended from the NHS should be able to continue to work in the independent sector, and I would be interested in your views on that, and, in particular, whether your experience is that the majority of suspensions are associated with the referral to the GMC?

(Dr Tomkins) I was listening to the answer of the BMA, which I agree with. The point about suspensions in the Health Service is that they can be for a number of matters, they may be to do with professional conduct, they may be to do with personal conduct, they may be to do with very circumscribed aspects of professional conduct, which do not impinge at all on a doctor's private practice. So, for example, you may have a Health Service obstetrician and gynaecologist whose obstetric practice is confined to his Health Service practice, and who practises only gynaecology in the private sector; and the allegations which may have given rise to the suspension may be confined to his obstetric practice. So I think to suggest that if there is a suspension in the Health Service perhaps there should be a suspension in the private practice automatically is not correct and would not be fair or reasonable, particularly if you take the view, as is set out in the Health Service guidance on suspensions,

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Julia Drown Cont]

that suspension is supposed to be a neutral act. And what we find, in practice, is that, very often, doctors are suspended from the Health Service, they do not know what the allegations are, they then find that they have been prevented from conducting their private practice and that they are the subject of journalistic inquiry, even before they themselves know what the allegations are and have a chance to answer them. Of course, if you have got a situation where a doctor is suspended in the Health Service because there is a very reasonable risk that he is a danger to patients then those other areas in which he practises, where he may also be posing a danger to patients, those people should be informed. But there are mechanisms for that; there is Health Service Guidance 97/36, which allows for that, where, if the Health Service suspend a doctor who poses a risk to patients, they may tell those in the private sector about the suspension.

(Sir Donald Irvine) But, actually, accepting that, this is an area where the system does not work as well as it might; given the notices of advice, they are not always consistently applied. We would welcome a closer relationship, and it seems odd that we are not told if a doctor is suspended what the reason might be, and, in your earlier question, you raised the question of safety. Now, at the very least, it would be sensible to have an arrangement whereby the Council is told, particularly if there are matters to do with practice elsewhere, so that, at the very least, we can have a discussion with the employer to find out what it is about; it may have nothing to do with safety, but if it has to do with safety then the best safeguard for the practice is not letters that go around but a decision made by the GMC whether the doctor should be suspended anyway, from practice anywhere, until the matter is resolved. So there is an intermediate step there, there is a gap that needs to be closed, in our opinion.

872. And is there any data on how many suspensions are also associated with referral to the Medical Council?

(Miss Nisbet) We do not have any accurate figures; anecdotally, we think it is only a proportion, only a small proportion.

(Sir Donald Irvine) But it is significant enough, some of the cases that we suspect where safety is an issue, and one dead patient is one too many.

Chairman: I think you are all aware that we are about to embark on a further inquiry which will relate directly to this specific area. The press notice, I believe, has gone out this week on controversial clinical outcomes, which I think will take us over this ground again in a good deal more detail, but it is very helpful to know what your thoughts are.

Audrey Wise

873. To the Medical Defence Union again. You suggest, in your evidence, that medical negligence litigation is a blunt and inefficient instrument for regulating the medical profession. Do you think that what is needed, or what could be done, is a sequence of conciliation, mediation and legally binding arbitration; is that practicable, or desirable?

(Dr Tomkins) Is that practicable, as part of a complaints procedure?

874. Part of a, whether you called it regulation, or whether complaint, in a way, it touches on both, does it not; when things go wrong? At the moment, as your own evidence says, and as our preliminary thoughts arising from other inquiries have indicated, people's wishes may be expressed through bringing litigation, but really could be expressed better in other ways, the desire for an apology, the wish that other people should not have the same problem in the future, that sort of thing. That is why you say litigation is a very blunt instrument; and, as the Chairman says, we will be exploring this in more detail. But, in relation to this particular inquiry about the private sector, where there are fewer avenues for patients, do you think that there could be conciliation, mediation and legally binding arbitration?

(Dr Tomkins) I think the key is to have a good complaints system in the private sector, and our experience of the complaints system in the NHS is that, on the whole, it works fairly well. We find that over 90 per cent of complaints can be resolved at the local resolution level, which involves the doctor meeting with the patient, perhaps with a conciliator, to provide the explanation, to provide the apology, if things have not turned out as the patient had hoped they would, and, where it is appropriate, to explain what went wrong and what steps are going to be taken to stop it from happening again; and that does work very well. What we are suggesting is that, in circumstances where that has not resolved the matter, the Ombudsman might be the right person to whom the patient could take the complaint. That is the complaints procedure, and the purpose of the complaints procedure is to provide the patient with the explanation that he, or she, seeks. The question of compensation is an entirely separate issue and one which involves quite complex issues of liability and causation. And when a patient embarks on litigation what they are seeking is, well, the purpose of litigation is to provide that patient with compensation for the damage which has been the result of the negligence, and not to provide an explanation and details of how this would be avoided in the future. If a patient has got to the end of the complaints procedure and feels that they would wish for compensation, at that point, I think it would be entirely appropriate for both the parties to have the opportunity to enter into legally binding arbitration, to try to deal with the issue of compensation; but it is a separate question from the complaint.

875. So what you are saying, I think, is that in the private sector there should be conciliation and mediation, and if that still leaves the matter unresolved then there should be recourse to the Ombudsman? And there should be, additionally, or could be, with advantage, some legally binding arbitration system, in addition to the normal litigation which exists now?

(Dr Tomkins) Yes. If, on the separate issue of compensation for negligently-caused damage, the patient is considering litigation, there arbitration certainly should be a possibility open, with the agreement of both the parties; and that is absolutely consistent with the view that Lord Woolf takes, with his 'access to civil justice' reforms.

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Audrey Wise Cont]

876. Going back to the conciliation and mediation bit of this, who do you think should operate such a system; because, in the NHS, for instance, if it gets to the professional review stage, consultants are brought from another area, another Trust, another part of the country, usually, in order to give their view, and there is a degree of independence there, it is not all within the hospital which is involved in the complaint? Now, because of the nature of the private sector, a whole lot of competing units, this may not be quite so readily accomplished; so who do you think should operate the scheme?

(Dr Tomkins) I agree with all those points, I think you are absolutely right, that it is much more difficult, because of the organisational structure, or sometimes lack of it, that underpins the private sector, to have a coherent complaints system of the type that you have in the NHS. I think the problem does particularly arise with setting up the independent reviews, and, in fact, the independent reviews are the area of most difficulty in the NHS system, the area which causes the most dissatisfaction, as far as both the patients and the doctors are concerned. I am not sure that it is necessarily a requirement of a good complaints procedure to have an independent review, particularly if you are dealing with a situation where the doctor and a patient may call into question the independence of those who might be making the review. I think some points were made with your earlier witnesses about the independence of, say, a Medical Advisory Committee and the appointment of independent assessors from that body. I think there are real difficulties of potential conflicts of interest there. But, as I said earlier on, in our experience, 90 per cent of complaints can be dealt with at the face-to-face, informal resolution stage, and it might be possible, even without an independent review stage, if the Ombudsman were to be involved, to have a satisfactory complaints system, which instead of involving the three stages involved two.

(Mr Hoppenbrouwers) I wonder if I can just add to that, Mr Chairman. I think conciliation and an independent review are two entirely separate things. In the Health Service, at the informal resolution stage, the health authority will employ trained lay conciliators at local level to help resolve the matter informally.

Chairman

877. The health authority?

(Mr Hoppenbrouwers) The health authority.

878. Not the Trust?

(Mr Hoppenbrouwers) Not the Trust.

879. This is news to me.

(Mr Hoppenbrouwers) If it is general medical services, general dental services, it would be the health authority.

880. So this is a common arrangement?

(Mr Hoppenbrouwers) Yes.

881. Applied all over the country?

(Mr Hoppenbrouwers) Yes.

882. Well, this is very interesting, you learn something new in every session. I do not know whether any of my colleagues are aware of this, but I have dealt with numerous complaints and I have never come across that system; so, thank you for that comment, it has been very helpful. Can I, in a sense, take us on from that, on the issue of the patient's circumstances, and I think it was Sir Donald who made the point about where does the patient stand in all this, and the patient is frequently baffled by the system, and that we need to pursue it from the patient's angle. One of the areas that I think we touched on briefly, earlier on, and I was not clear on your response, from the GMC point of view, relates to where a member of the public, a potential patient, or patient, can obtain information from the GMC about in which specialty a particular doctor is registered. And one of the concerns we had raised with us last week is the way in which the Specialist Register is apparently failing to protect people who want to know whether the doctor that is going to treat them, or has treated them, is appropriately qualified. I think you actually touched on that briefly earlier on, but could you expand a little bit more, because I was not clear as to why I, as a patient, if I need to know whether, and if I go to have my car fixed I can check on the wall whether the person concerned is appropriately qualified to mend the vehicle, but the system with regard to GMC seems somewhat different?

(Sir Donald Irvine) If I can just take the General Register, the General Register, of course, is published, we have taken a lot of steps recently to improve the accessibility of the Register to anyone.

883. We are more concerned with the Specialist Register, that is the area where we have had presentations, as you will appreciate?

(Sir Donald Irvine) Yes; but, the Specialist Register, that is also publicly available, that information can be found directly from us. I think the point had been made that we have not made that information available, I think that had arisen in some earlier evidence, and I just want to dispel the notion that it is not available; it is.

884. So what you are saying to me is, if I am considering having some, say, cosmetic treatment, and the person concerned, if it is private clinic or hospital, puts forward the view that they are an appropriately qualified specialist, I can find out from the GMC whether that particular consultant is qualified in the specialism in which he, or she, will be treating me?

(Sir Donald Irvine) I think this comes back to the earlier point, and—

885. I was not clear on the answers on that?

(Sir Donald Irvine) What I said earlier, if I could just rerun it, because you make a very important point, is that the decision was made by Parliament to construct a Specialist Register which would describe doctors who had been certificated in an area of practice, surgery, psychiatry, etc. What it would not do would be to tell you whether this doctor was an expert in hair transplants, or hernia repair, or a particular form of counselling technique. And the reason why this was so is that a line has to be drawn somewhere, and the decision was that it should be at

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Chairman Cont]

a higher level of description rather than the very particular. The problem with the particular, if you look at regulating systems elsewhere, is that it is very difficult to know that doctors are sticking to that, that the information that the user of the Register, or the interrogator of the Register, thinks they are getting is actually what the doctor does.

886. But do you feel it is unsatisfactory, at the present time, for a patient to be misled into believing that they are being treated by somebody who is appropriately qualified, as a specialist, he is on the GMC Specialist Register, when, the treatment that they are actually about to undergo, this particular consultant is not appropriately qualified, has no expertise in that area? This is the evidence that we are receiving, which is causing this Committee, as you will appreciate, a good deal of concern?

(Sir Donald Irvine) Yes, I understand that, and I think there is a genuine problem here, but the answer to it, probably, lies less in trying to clarify and be more precise about what exactly the Register says, but rather to follow the line of your original questions to me, is this doctor, at the time of practising, doing whatever it is to the patient appropriately, skilfully, safely, competently; that is what the Register does not answer, at the moment, and that is the point of us introducing the revalidation arrangements. That may become clearer, if I just say two or three words about what exactly that will entail. So it will entail knowing, on a continuous basis, by methods that have got to be established, but we have got a lot of experience of this, that the doctor actually is knowledgeable in the areas in which he is working, and using information from a number of sources that the doctor's actual performance with the patient is appropriate and safe. So what we will see, in two years' time, is a profile of a doctor's practice, a doctor at work, and that information available both to the doctor, to any employer and to any patient, I think that is the important thing.

887. So you see this gap being addressed in the very near future?

(Sir Donald Irvine) Yes. I understand the problem of description. We are going back into the question of description, as we look at the Specialist Register, but it would be wrong of me to create the impression that, simply by being more specific about what the Register says, somehow that will address the question the patient wants, what the patient wants to know is "Am I safe in this doctor's hands?"; well, that is what the GMC wants to know, as well, and we want to make sure that that is closed and as watertight as possible. It addresses the other problem that you have not touched on but from a patient's point of view is very important; the matter of safety is not limited to whether a person complains, and there is evidence, from other countries, but we have our own evidence here, in the operation of our performance procedures, that there is dysfunctional and at times, frankly, safe practice which patients are perfectly unaware of, and we have seen some evidence of this recently. So the whole point of getting the doctor to put on the table regularly the evidence of his, or her, fitness to practise is another way of closing off this kind of gap. We have had two cases before our performance procedures recently,

where we suspended the doctor as not fit to practise, but there had been no patient complaint; so it is a very important step, this, in taking public safety forward.

Mr Gunnell

888. A question for Dr Mitchell and Dr Jay. Your Guide to Standards in Private Practice suggests that the contractual relationship with the client should be clarified at the outset; what do you see as the main problems of that? And how satisfactory is it that some patients, as we learned from evidence a couple of weeks ago, undergoing cosmetic surgery pay in full, in advance, for their treatment; what particular problem does that give you? And what are the problems of contractual relationships in general?

(Dr Mitchell) Could I start with a little introduction about what, up till now, has not been expressed, about what private general practice is about. I write lengthy referral letters to consultants to whom I refer my patients, and I expect to get fairly comprehensive replies back within a very short time, because in this day and age, with fax machines and e-mail, and so on, there should not be months between communications. On occasion, I attend consultations with specialists. I certainly, almost invariably, attend operations, when my patients have surgery. I look after my patients in private hospitals; it is not easy to look after patients in National Health Service hospitals, the GP role there changed in 1948. And I know all the consultants to whom I refer patients. So a lot of the issues that have been raised this morning, if only patients were in this position apropos their general practitioners, private or National Health Service, just would not arise. And the contractual relationship is one which is, in the private sector, between the patient and the doctor, and it is not between the patient and the insurer and the doctor, in that order; but patients will arrive, saying "I've got my BUPA card here (or my PPP card)", as if it is a credit card, or a charge card, and it is not, it just gives information about their number. And we all stress that, when you are seeing a specialist, you check with your insurance company, get their approval, because in this day and age some of them have to be on their approved lists. I am not happy about this, as a GP, and I do not think that I should have to refer to their preferred providers when I have got my own list of consultants who can cope with these particular problems. And then it is for the patient to negotiate with the insurance company, for the insurance company to pay the specialist; any shortfall is something for which the patient is responsible. And this avoids all the problems of "Oh, no, BUPA (or PPP) will pay you, it's got nothing to do with me", it is a direct contractual relationship, because, otherwise, the insurers come between the patient and the doctor, not only financially but in terms of responsibility. And, by having this system, in which we refer our patients to specialists, the specialists deal directly with the patient, we endorse the claim forms that we have referred the patient and that the consultant is an appropriate specialist, then there really should not be any problems. But, to go back, if I may, very briefly, the idea of the GMC having all the information

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Mr Gunnell Cont]

about different specialists, it will never be absolutely up-to-date, because, unfortunately, even, for example, in the Independent Doctors Forum, where we are trying to audit each other, one eye surgeon will tell you about half a dozen eye surgeons "They all actually work in different compartments from me, I really do not feel in a position to judge them." Orthopaedic surgeons these days are ankle men, knee men, shoulder men, hip men or back men; there are general orthopaedic surgeons, but they are becoming much rarer birds. There are sources of information, the British Association of Plastic Surgeons, for example, will send you a list; there are various help lines, London Medicine, which is part of the London Tourist Board, are accumulating information; there is one in Harley Street, called the Harley Street Bureau, where patients can get information. There are sources, and these, obviously, need to be publicised without advertising the skills of individual doctors, because that is where one would fall foul of the GMC. So information is becoming available, and the Independent Doctors Forum is very concerned that that should be so. We do not approve of clinics which advertise services but you have no idea who works there, and therefore you have got no means of finding out. You can find out more about doctors and specialists if you look up the Medical Register, because there is very often a career pattern, and you can see that someone has written a lot of papers, on kidney stones, so obviously this chap is probably good for dealing with your patients' kidney stones. I remember one young man who worked in a private clinic in the cosmetic field, and part of his CV said that he had worked at East Grinstead; now that sounds great, because it is one of the top plastic surgical centres, until you look up the Medical Directory, and he was an SHO in obstetrics at East Grinstead, so he is not really entitled to be thought of as an East Grinstead plastic surgeon, but he called himself a consultant, he had got no higher qualifications. One can find out though, if you are in the profession, and it is up to patients, I would hope, to consult with their GPs, so that the Chairman would have spoken to his GP, and he would say "I never refer patients to that clinic, but if you go to see Mr ..., in Harley Street (or Park Square, in Leeds, or wherever), I know him and you will be well looked after." I do not really want to imply that everyone can have this sort of medical service, but there is a lot more good medicine goes on in the private sector than we hear about, from all the complaints this morning, and I think complaints in private general medical practice are relatively rare because the patients choose the doctor, and if they do not like you, well, they go elsewhere. In the Health Service, they are registered.

Chairman

889. Can we go back on to private general practice in a moment or two, because I would like to ask some questions on that specific area. Dr Jay, do you want to respond to Mr Gunnell's general points, or any other of the issues that have been picked up so far?

(Dr Jay) If I may respond on the contractual issue, because it does give some concern. I think you are asking, does the patient know who pays, how much and when, basically, and that needs to be discussed openly.

Mr Gunnell

890. Really, do both parties know, because there are two sides to a contract, so it is whether both parties know exactly what the arrangements are?

(Dr Jay) Patients are often distressed and bewildered when they are appearing in front of a doctor, it is even worse than a Health Service Committee, perhaps, and they do not ask the questions they should ask, and there needs to be much more careful explanation than normal at that point. I have even had the experience of patients coming for private consultation who actually think they are getting an NHS service; so it can be as fundamental as that, the very basic level of making that clear. There is also, what should be done when things go wrong, because the distress is even greater there, and, at present, you have heard the different responsibilities of hospitals, insurers and doctors, and they are separate, but they need to be integrated, so that, at the very least, the patient has a common entrance point to a complaints procedure. Within that procedure, there may need to be some division of responsibility, and that is quite difficult to work out, and that is partly why we are having some difficulty getting the details. And, just finally, you mentioned the question of patients responding to the blandishment of high pressure salesmanship, where they may be actually asked to pay even before they see a doctor, which is quite unsupportable.

Chairman

891. I thought these things happened regularly?

(Dr Jay) It is unsupportable.

Mr Gunnell: It seems to be how they sell some cosmetic techniques, by getting them to sign up for it and pay for it straightaway, before they get into it.

Chairman

892. We were told last week it is normal, mainstream practice, by some of the providers that we had here last week, and you are saying this is unsupportable?

(Dr Jay) When patients are paying, in private practice, for a procedure, not supported by an insurance company, it is, I believe, normal practice that the hospital requires payment in full for the standard procedure before they are admitted for the procedure, which is, I think, quite different from being asked to pay for something before it has even been considered, before the whole implications are discussed, and time goes by, that they agree that they do want the procedure, have a time for consultation with friends, relatives and their general practitioner.

Mr Gunnell: I do think that, in some cases that we have heard about, we felt that, really, by getting them to pay in advance ensured that they would go through with the treatment, and that seems very dubious practice.

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

Audrey Wise

893. I think that an answer to a previous question by you, Dr Mitchell, has probably pretty well covered the thing I was going to ask. I will just make sure. You said, in your evidence, that you, that is, GPs in private practice, are the reluctant gatekeepers for private insurers; now, in answer to my colleague, Mr Gunnell, you talked about the insurers having their own preferred lists for referral, and you are not happy about that, because you would prefer to refer on the basis of your experience.

(Dr Mitchell) My preferred list; yes.

894. Was that the reason for this term reluctant gatekeepers for the insurers, or is there more to it?

(Dr Mitchell) That is the main point, that we are, as GPs, no longer in charge of referrals, it is not dependent on our experience and our relationship with consultants, the insurers are intervening, they have a preferred list, and so on. The difficulty is that they have large numbers of insured patients who want private treatment; they go to their GP, who says "I'm in the Health Service, I don't know anything about private treatment", and they will then try to go back with a name. So that the patient is being referred to someone that the GP does not necessarily know, and the name that the patient will present is somebody recommended by the insurers, they think "They must be good if they work for this particular ..." But it is bypassing the GP's real gatekeeper role in protecting the patient.

895. So what you are saying, I think, is that you would not object to a recommendation, a recommended list, as an adjunct, if the GP did not have a view, then that could be a second line, but it should not be a preference?

(Dr Mitchell) Yes, because patients do need information.

896. Do you have a view then on the next stage in that, the development of the BUPA Partnership arrangements, which obviously will influence who is on that preferred list, do you think that that is going to intensify your reservations, or are you happy about it; if you are not, who should do something about it?

(Dr Mitchell) I have slightly mixed feelings about the BUPA Partnership, because, in fact, it seems to be working well. This idea of a bonus is really a very small sum, and I think that it was something to dangle before the profession, to pull them into a new scheme. And I think it would be much better if it fell by the wayside and that they devised some other aspect of the scheme, because it actually improves the payment, it lessens the amount of form-filling for claims, and BUPA are getting a lot of information about medical practice, which is allowing them to audit doctors. So I do not feel entirely comfortable about this, I think we should be auditing ourselves, but somebody is going to do it, and we do need the information. What worries me is, if they lay down very strict criteria and say "The average time, after a hernia operation, for an inpatient is 36 hours, you're keeping your patients in for three days; you're exceeding the average and we are not going to pay for in excess of 36 hours"; that is going to fall on the patient. Or "You are not abiding by our protocols, we are going to withdraw your recognition." And I

do not like the idea of the insurance companies auditing doctors and then deciding who will or will not work for them. Again, as I have indicated, by going along to patients' operations, by getting involved in the gossip amongst anaesthetists, who are a fantastic source of information about how good, or not so good, surgeons may be, I have got a lifetime's experience of how to work, how to operate, in central London. And I am not dependent on using any one particular hospital, any one consultant, any one pathology lab., my work is sent to whomsoever and wheresoever I think my particular patient, with that particular problem, is going to get the best service. And I do not like insurance companies laying down rules and regulations because they have come to some fortunate financial arrangement with a scanning company, or a laboratory, for example; that, to me, is interfering with clinical freedom.

897. I think this next question might be for Dr Jay, most appropriately. When the Committee went, some years ago, to the USA, I was very struck by evidence of interference by the insurers, which was really effective interference with clinical judgement, although they claimed it was not; it was done in America because, of course, insurance is dominant in America. I am not aware of this arising here, because insurance is in a different relationship and it is to health care in general, but, of course, it is always a possibility. That is, suppose you are a surgeon in a hospital, this was put very strongly to me by a surgeon with the Massachusetts General Hospital, which is a very highly regarded hospital, who told me, in particular, that, if he wanted to keep a patient in for an extra night, or an extra day or two, or over the weekend, he, first of all, had to contact the insurer and that it was very much the practice of insurers to say "Well, of course, it is up to your clinical judgement, we're not going to interfere with that; however, we are going to tell you that we're not going to pay for it." Which meant that either the surgeon discharged the patient, because otherwise there was no payment for the hospital, or kept the patient, knowing that there could be no payment and yet there would be costs incurred, and the hospital, of course, would want to break even, at least, and could not afford to carry too many situations like this. Now he felt that that was an interference with his judgement. What would you feel; do you feel that this is a danger, in any overzealous examination by insurers?

(Dr Jay) It is a danger, certainly, and the examples you give are well rehearsed, and may even be slightly different with the development of health maintenance organisations in the United States, where you have to go to a given unit to provide the care; it is a different version of the same problem, and, unfortunately, we are increasingly facing it in National Health Service practice as well. And I think the common key here is that modern medical practice is now so successful, the demand is particularly high, and that funding the whole edifice is becoming increasingly difficult, even for the United States economy, the private economy, let alone the health economy. And I think you were describing one of the stresses and the conflict between what the country, in the general sense, can afford and what is on offer, in

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Audrey Wise Cont]

medical care; it is of great concern. But it is, I think, with respect, a far wider problem than the very narrow instance of just insurance.

898. You said that there should not be a learning curve, as far as patient safety is concerned, but we have been told that it is quite common practice for a resident medical officer, in a private hospital, to have to cover a wide range of specialities, out of hours, overnight, or whatever, and that the consultant does not spend as much time in that hospital as may be justified by the number of patients, because he is doing work perhaps in the National Health Service. Do you think this is a problem, any of our witnesses, and, if you do, how would you wish to see the staffing arrangements changed; so are people, are resident medical officers being asked to cover for too wide a range of specialities, and, if so, how do you resolve it?

(Dr Mitchell) I visit my patients every day, and the RMOs are there as back-up, because they are there in the middle of the night; if someone collapses, I might take 20 minutes to get in. I expect my patients to be visited by their consultants, if they are under the care of another consultant, because I do admit some patients in my own right, but if they are post-surgical I would expect the consultant surgeon to see them every day. And the commonest time for seeing people in London is about half-past six, seven o'clock in the morning, before they go in to do their NHS sessions; so patients may be sort of rudely awakened, but at least they are seen and they are examined. If something goes amiss, when I first started in private practice I had a diary with an address book, I now have a Psion, because I need to have the specialist's home telephone number, office number, office fax, his bleep number, his pager, and possibly his e-mail address, and this allows me to catch up with him wherever he might be. And I have spoken this week, not to involve a surgeon directly in coming back to see a patient, but he was in a hotel in Paris, and I got him on his mobile; so we can keep tabs on the specialists who look after our patients in the way that we would expect them to be looked after, and I would not use a specialist who went in to see a patient once a week. And that is not just a private medicine phenomenon; it is probably less in the National Health Service now, but there used to be chaps who did a lot of sessions in London and then perhaps one in Tunbridge Wells, or one in Guildford, and they would only be there for one day, so the junior staff were responsible for the welfare of the patients thereafter.

(Dr Jay) I think the problem can be dissected into two levels; one is the support available for the acute episode if a patient takes ill out of hours, and that is the same problem in any hospital. Acute care is almost a sub-specialty, which our young doctors are usually well trained in, and especially if they have advanced life support certificates, for example; and then, when the patient is supported and stabilised, at an appropriate interval, a definitive team is available then to come in for the problem. And I believe there should be no real difficulty in cross-covering for multiple specialties, it happens in large NHS hospitals, a senior house officer will be on call for many wards, sometimes for patients he, or she, may not have ever dealt with before. So there is a need to make sure they are properly trained, with the right

level of skills, to hold the fort, if you like, until the surgeon, or surgeon plus anaesthetist, or whatever is necessary, is available; if a surgeon is doing something else then there must be alternative arrangements made for a colleague, or colleagues, to help out, and, again, that will happen whether it is in NHS or private practice.

(Sir Donald Irvine) I would just like to underline that point. I think we are talking about a general principle here, that doctors who share care and who may delegate have to do so in the knowledge that the arrangements they make are consistent with patient safety. It is an area which is causing concern both in the Health Service and the private sector, but I think it is an area where we are certainly doing our best to raise the profile of this. There is very explicit guidance, again, on page 11 of Good Medical Practice, about what those responsibilities are. I think, also, that we are, I hope we are, seeing management, wherever they are, being far more aware of their responsibility to ensure that people providing cover are appropriately trained. It is distressing to us to find that, despite the fact that we have made our Register as accessible as it is, it is still quite commonplace to find that institutions, in both the Health Service and the private sector, do not always find out, for instance, that people that they are engaging for short-term cover, locum's, and so on, are actually properly registered; it is at that fundamental level. So there is a gap.

899. What should be done to an institution which is so careless?

(Sir Donald Irvine) It ties back to the earlier question of how far we take, as a country, the matter of external review; we have no history in this country and in the Health Service of doing that. I am speaking entirely personally, but I think that has been a significant gap in our health arrangements, and we are driven back to my starting-point to you, what we need is a combination of good managerial, personal practitioner and patient dimensions. I think the other point that we have not mentioned, but I think we will see far more about it, is the extent to which patients themselves are now far more questioning, and the kinds of questions they ask is not what does the Register say. I was talking to an ex-patient of mine just last weekend who was going to have an orthopaedic procedure done, and she said to me "The person I'm going to, he doesn't have a good name, you know, that is to say he's a pretty awkward character, but I suppose he's quite good at the technical side of it." And we then had a very interesting conversation about the inquiries she was making at the level of knowing what his personal performance was; now, if you ask patients, that is what they actually want to know. It is very interesting to see how assertive people are becoming now. They are also, of course, bypassing doctors, of all kinds, and going straight to the Internet, to have an independent check for themselves, not only about the doctor but about the condition, what it might be, what the possibilities of treatment are, etc., and I think this is something that many doctors find quite perplexing. I personally believe that it will lead to a far better, healthier and more robust relationship between patient and doctor, but it represents a

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
 DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
 MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Audrey Wise Cont]

transfer of power in the doctor/patient relationship from the doctor to the patient; if I were a patient, I would welcome that.

900. As a patient, from time to time, I do welcome it, and I know how difficult doctors find it. But something has occurred to me, arising from a statement made by Dr Mitchell, about his patients in the private sector being visited by consultants and it being commonplace at 6.30 to 7.30 in the morning because that is when they can fit it in, and I wonder if any of the witnesses have any views about the competence to practise of a doctor endlessly, over time? It seems to me that a doctor may be very competent, very competent on paper, very competent within reasonable hours of work, but it does seem to me to be very questionable whether that competence can be reliably regarded as existing morning, noon and night, seven days a week, and yet that seems to be a common way that doctors practise, first of all, from the culture and training things with junior doctors, and then, when they become consultants, it seems to me that some carry on in exactly the same way but they do the extra hours in private practice. And I would think this is detrimental both to patients in the private sector and in the NHS. One of the things I would want to know, but I have no idea how I would find out, is whether anybody treating me was actually working a reasonable number of hours, so that I could be reasonably confident that he would be awake and his reactions would be suitable. And do you have any views about this; should somebody be taking some more robust, to use your term, Sir Donald, attitude on this? It does seem to me, as well, that matters arise of the example given by the medical profession. I am frequently filled with scepticism, because it does seem to me as though they live extremely unhealthy lives and it may well affect their ability to advise me, let alone operate on me. Do you have any views?

(Sir Donald Irvine) If I could perhaps just say that you are hitting the nail on the head as to why we are placing such attention on performance, what the doctor does, and over a period, not what the doctor knows; it is perfectly possible to be quite competent "I have the knowledge, I have the skill" and not to apply it, or apply it consistently, and what the patient wants to know, as you say, is that it is applied consistently. And, of course, that will be at the guts, at the very nub of the revalidation process, a picture of the doctor at work, on a fairly continuous basis. If it raises questions, as in certain circumstances I have no doubt it will, about the appropriateness of the doctor's working time, well then that is something that the management and the doctor have got to discuss. The key thing is making these things more explicit than they have been, and doing it in a systematic way, covering all areas of a doctor's performance; it is a very important distinction between performance and competence, and we are going for performance, what the patient gets, not what the qualifications look like.

(Dr Mitchell) Very briefly, if it is a surgeon, his anaesthetist could tell you whether he has retained his competence. Some of these are people of tremendous energy, they do not need very much sleep, they are incredibly active; there are others who need regular weekends off if they are going to put

themselves under this sort of pressure during the week. But this is the point about visiting one's patients, going into hospital, talking to the surgeons, talking to the anaesthetists, the gossip, the anecdotal evidence, and then knowing that they are still capable of working. I think it is probably reasonable that surgeons give up actively operating, say, at the age of 65; some of them carry on in the private sector up to the age of 70 and then that is it, but they can be superb second assistants, giving their wisdom and their experience, but they are not literally involved at the cutting edge. So that, as we get older, I think we all realise what our stamina can cope with, and the hours that we worked as housemen and registrars would be inconceivable at the present time, but you can still work well into the night with the stress of a very demanding medical situation, but you now need a bit of time off the next day, or a couple of early nights to follow. It can be done, and it is outside normal working hours, and it is one of the ways that doctors, I think, enjoy private practice; and the long hours, the being involved in work, may be not conducive to good marital relationships, relationships with children, these are other things that we have got to come to terms with. But I do agree with you, and I do take the point, that some people actually deliberately put themselves into a position where they work long hours, which they find, the adrenalin buzz is great for them, but they do first-class work whilst they are at it.

Chairman

901. I realise we are testing your stamina. Dr Jay, do you want to comment?

(Dr Jay) If I may, just to respond on that. There is a lot of concern about hours of work of doctors, the trainees have had this problem for a number of years, and that is better dealt with, the hours are reduced, better controlled; in turn, that has thrown a considerable load on consultants, who are now doing much longer hours, with the additional loads of administration, management, better auditing, all the things we have talked about, but the patients have not gone away. And there is concern particularly expressed by the Royal College of Physicians in London, it seems to be a particular stress at the moment for consultant physicians across the country; paradoxically, surgeons may be able better to demonstrate their workload, because they have so many hours in the operating theatre and the number of hours you can spend there are limited by the facilities available, whereas physicians can have more patients and longer hours, but, yes, it is a problem of concern. We may need more doctors, we may need to organise health care differently.

902. Could I raise just one point, which I promised, Dr Mitchell, to come back to you on, which was the issue of private general practice, and you were possibly here for the first session when I was raising the question of BMA reservations about walk-in practices, the increasing advent of walk-in practices, which is a whole new area that perhaps we have not really caught up with, and the Committee went to one yesterday, as I mentioned earlier on. You, presumably, picked up the point that we raised about the relationship with the NHS GP, if there is one;

29 April 1999]

SIR DONALD IRVINE, MISS ISABEL NISBET,
DR GEOFFREY MITCHELL, DR CHRISTINE TOMKINS,
MR RUPERT HOPPENBROUWERS AND DR JEFFREY JAY

[Continued]

[Chairman Cont]

what were your thoughts on that point, about the collaboration between the walk-in practice, the GP in the walk-in practice and the actual NHS GP, where there is that NHS GP?

(Dr Mitchell) I have great reservations about walk-in practices, because of this problem of keeping records and of communicating with other doctors who may be involved in the patient's care. I can see that it fulfils a need in acute circumstances, with someone being taken ill in town and being able to go into a station, but most of the doctors working there are not full-time private practitioners, they are not committed to private practice, they are moonlighting, or whatever, from the Health Service. And I am worried about the communication element; patients do not always tell a complete and accurate history, and unless they actually write to GPs fairly quickly and inform them that the patient has been there I think that the whole system is actually not in the patient's best long-term interests.

903. Do you have any thoughts on what should be done about regulating those walk-in clinics?

(Sir Donald Irvine) Could I just offer you one piece of information. Page 13, paragraph 43, addresses the questions earlier and the question you have just asked now about the responsibilities of doctors

accepting patients in those circumstances to communicate, and if either the patient does not wish that, what it is that they have to do to ensure continuity, etc. It is set out in paragraph 43, as part of the duties of a doctor.

(Dr Mitchell) So, provided communication is established, and obviously it is wrong not to, but that must be enforced, they may fulfil the need, but I do not see it as an ideal form of patient care, because I do believe in having a personal doctor, NHS or private, and continuity.

904. Do any of the witnesses have any further points they wish to raise?

(Dr Mitchell) A quickie. If the BUPA bonus to its participating members is interpreted as fee-splitting then it is proscribed by the GMC. That could be a way of dealing with this problem, if it is a problem.

Chairman: Thank you. Can I thank you all for your very helpful evidence. I am sorry we have kept you so long. It has been a most valuable session. I appreciate that one or two of you, certainly, Sir Donald, you promised to follow up with some written information; we appreciate that. Thank you very much for your help, we are most grateful to you. Thank you.

Supplementary memorandum by the RCN

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE (PM 62A)

Q: The view that regional Commissions for Care Standards are the best mechanism for regulating the independent sector was a minority view in our evidence—can you tell us what persuades the RCN that CCSS would be the best regulators?

The RCN believes that extending the remit of the regional Commissions for Care Standards regulators to include independent health care would lead to the following benefits:

- better integration and sharing of expertise;
- better use of infrastructure;
- a regionally-organised system should lead to more consistency, and less fragmentation;
- cost efficiencies and economies of scale; and
- fewer inspectorates meaning a clearer and easier system for the public to understand.

However, the RCN believes that for this model to be workable, it would be essential to ensure that the Commissions for Care Standards were staffed, resourced, and described, in a way which recognised that their responsibilities covered a spectrum of health and social care. This would involve recruiting multi-disciplinary inspection teams, with inspectors from a range of backgrounds including both health and social services. Inspectors would need to have adequate expertise and training, and the skill-mix of inspectorates would need to be properly addressed. In addition, the successful implementation of such a model would depend on:

- updating the framework for inspection and regulation;
- a greater focus on outcomes, patient welfare and clinical care, rather than just on processes and facilities;
- greater consistency of inspection standards and use of national benchmarks to eliminate inconsistency and variations in inspection practices; and
- better enforcement mechanisms, allowing inspectorates to give help and support to providers to address weaknesses, rather than simply threatening closure.

These changes are needed as much for nursing and residential homes as for providers of acute and specialist care. The RCN does not think it is sensible to try to create a strict distinction between "health" and "care" and then try to devise separate regulatory systems for each, as there will always be providers and types of care which fall into the "grey area" between the two. Indeed, much of nursing is about bridging the gap between

29 April 1999]

[Continued]

“health” and “social” care. Just as old barriers between health and social services are beginning to be overcome, the RCN fears that having separate inspectorates along these lines would create and re-enforce new barriers.

The RCN believes that it would be preferable to have a single integrated inspectorate in the form of the Commissions for Care Standards, rather than creating a new separate inspectorate for the acute independent sector, for the following reasons:

- a separate inspectorate would mean extra bureaucracy
- there would be extra costs associated with administration, overheads, lack of economies of scale
- greater possibility of inconsistency in standards
- the independent sector is still very wide and encompasses many different types of provision, so the need for a wide range of training and expertise would remain and not be resolved by having a separate inspectorate for the independent sector
- a separate inspectorate would mean a different culture, making exchange of ideas, best practice, etc less likely than within a single organisation
- this model does not address the gaps, overlaps and “grey areas” such as long term beds in acute hospitals, hospice beds within nursing homes, and providers which use a combination of acute and nursing home beds working flexibly

It has been argued that the new Commission for Health Improvement should take on the role of regulating independent health care. The RCN does not agree with this argument. Although we believe that the Commission will have an important monitoring and inspection role, its functions do not include registration and issuing licences, and, crucially, it does not have a statutory enforcement role. It would distort the Commission’s role to take on such a licensing function, and it would have to make much more frequent inspections and have to have much bigger workforce, and would be less able to concentrate on driving up quality.

Q: Do you think the role of the Mental Health Act Commissioners should be expanded to take in regulation of the independent mental health sector, from forensic psychiatry to non-acute nursing homes for mentally ill elderly people?

Mental health has been a huge growth area for the independent sector in recent years. The RCN recognises the importance and expertise of the Mental Health Act Commissioners, but points out that their current role is not primarily as an inspectorate. If the MHC were to take on an inspectorate role, this would involve a radical reshaping, including new statutory powers, new administration functions, and radically changing their workforce. The whole emphasis of their role would be different, and the RCN is concerned that it could lead to a more diffuse focus, with less attention paid to patient welfare.

The RCN also points out that mental health is not the only specialist area that inspection and registration officers have to assess. There are lots of other areas of clinical speciality. Thus, the RCN believes that rather than create inspectorates according to clinical speciality, the key issue is to make sure that inspection officers have the right training and expertise, and that this applies across the board, not just in mental health. Partnership working will be essential to this approach, and the RCN believes that inspection teams within the Commissions for Care Standards and MH Commissioners need to work closely with each other, and each be informed by the other’s work.

Q: You mentioned in your evidence that the RCN had commenced work on training and skills for registration and inspection officers; what progress have you made and how do you think national standards and benchmarks would be most consistently and effectively achieved?

The RCN has long been interested in this subject, and in 1994 published a report *An Inspector Calls*, about the skills and training needs of inspectors. More recently, the RCN has produced a paper on skill-mix, competencies and training of inspectors, and has been liaising with the Universities of York and Anglia, which are the only two universities to so far develop courses for inspection officers. The RCN has also just begun to work closely with the Department of Health’s Inspectorate Training Working Party.

The RCN has a number of other suggestions for making sure that national standards and benchmarks are more consistently achieved:

It is important to set national standards for training of inspection officers eg through training programmes for inspection and registration officers such as those being developed by Universities of York and Anglia.

Having inspections organised on regional level should help, as it should lead to greater consistency, and make it easier to share/exchange best practice, compared with the current system where each Health Authority has its own inspectorate, leading to huge variations.

*29 April 1999]**[Continued]*

The RCN suggests that we could eventually have a requirement or an expectation that no-one will be appointed to be an inspection officer unless they have undergone a relevant training programme, although this will take time to implement and is not realistic as an option for immediate implementation.

There is a need for professional development and in-service training for inspection officers, to keep them up-to-date with developments and changes. Inspectors need to keep up-to-date with developments such as National Service Frameworks, national benchmarks for care standards, and Integrated Care Pathways, so they are aware of what constitutes good practice in terms of service-delivery and quality of care. Inspectorates need to work in partnership with a range of other agencies, such as NICE (so they are aware of the evidence-base for their work), the Mental Health Commissioners, CHIMP. Multi-disciplinary teams of inspection officers are also essential, ensuring a wide range of expertise, so that people are not expected to inspect in areas where they lack the necessary expertise.

It will be important to expand regulation beyond a "policing" function, to include a facilitative, supportive and advisory role too ie not just identifying what the weaknesses/failures are, but also looking at why they are occurring, and advising on how improvements can be made. This will help get away from a "checklist" approach to inspections, to a focus on problem-solving instead. Similarly, there is a need to shift in emphasis from inspecting facilities, to focusing on outcomes and patient wellbeing.

Q: You have reported a high proportion of disciplinary cases as relating to the independent sector—what do you think are the reasons for this?

This was not in fact in the RCN's evidence, although we do not dispute it. The RCN believes that the main reason for this discrepancy is that independent sector providers—especially the smaller ones—are less likely to have well-developed personnel and disciplinary procedures, compared to NHS. The result is that in the case of a problem or complaint, a nurse in the independent sector may be reported to UKCC almost immediately, whereas in a workplace where there are well-developed personnel procedures, a nurse would only be reported if the issue was not resolved following a detailed disciplinary process. The RCN believes that there is a need to improve and develop both patients complaints mechanisms and disciplinary and personnel procedures in the independent sector, and that this should lead to better outcomes for both patients and staff.

The RCN believes that the forthcoming Employment Relations Act should assist in the development of better personnel policies within the independent health care sector. The RCN has already developed a Voluntary Recognition Toolkit for use with independent sector employers of nurses, which is seen as a good practice initiative. The RCN toolkit was launched by Frank Doran MP, PPS to Employment Minister Ian McCartney MP, in March 1999.

The RCN reiterates our belief that independent health care providers should be brought under remit of the Health Ombudsman as a final, independent arbitrator, and that patients should receive clearer and better information on complaints mechanisms and their rights to make complaints if things go wrong.

Q: You mentioned that registered nurses working in the independent sector can encounter a conflict of interest between their professional accountability under the UKCC code of conduct and their business accountability, and that this can lead to extra pressures, and you ask for this to be better recognised. Can you give some practical examples of how these conflicts can be dealt with?

The RCN believes that raising awareness about the potential conflict of interest is important, as this in itself will help to create an imperative on independent sector managers to acknowledge the issue and give commitments to protect staff who speak out about clinical concerns (including issues surrounding the care of children, as raised during the oral evidence session). Employers who take on professionals such as nurses, who work to a professional Code of Conduct, must be prepared to acknowledge and accommodate that, and this should be formally incorporated into their employment policies. All managers and employers of nurses (in the NHS as well as the independent sector) should familiarise themselves with the UKCC Code of Conduct.

The independent sector has indicated its willingness to implement the agenda of clinical governance. One aspect of clinical governance is that nurses and clinicians should be involved in the planning, design and management of care, not just in care delivery. The RCN believes that involving nurses in the planning of care, and in decision-making at higher levels, should reduce the potential for such conflicts of interests. At present, nurses often find that such conflicts of interest arise when they are told of decisions with which they disagree, but are given no opportunities to influence or change those decisions, and therefore feel powerless. Clinical governance should mean that such potential conflicts of interest are identified, addressed and resolved at earlier stages.

Clinical governance should also mean putting in place mechanisms for genuine staff concerns and complaints to be raised in a way which does not lead to staff being disciplined or losing their jobs for raising issues. The aim must be to resolve issues before they reach the stage of "whistleblowing", although in extreme

29 April 1999][Continued

cases whistleblowing is likely to continue in health care, in both the NHS and the independent sector. There is now some legal protection for whistleblowers under the Public Interest Disclosure Act, although it is still too early to say how effective the Act is, and how much protection it affords in practice.

The RCN has a great deal of experience of working with nurses to develop guidelines about good and best practice in care delivery. Independent sector employers should be willing to work to such guidelines, even where they may clash with business imperatives. The issues surrounding cosmetic surgery treatments would seem a prime example of where there is an urgent need for such guidelines to be developed and implemented.

THURSDAY 13 MAY 1999

Members present:

Mr David Hinchliffe, in the Chair

Mr David Amess
Mr John Austin
Dr Peter Brand
Julia Drown
Mr John Gunnell

Mr Ivan Lewis
Dr Howard Stoaite
Mr Robert Walter
Audrey Wise

Examination of Witnesses

RT HON FRANK DOBSON, a Member of the House, Secretary of State for Health, and MR MARTIN STANIFORTH, Head of Corporate Affairs, NHS Executive, Department of Health, further examined, and BARONESS HELENE HAYMAN, Parliamentary Under Secretary of State, Department of Health, examined.

Chairman

905. Can I welcome you to this session. It is likely that we will be disturbed by a division in a minute but if we can make a start. Secretary of State, can I thank you for the evidence that you have given to us in writing. Mr Staniforth, we have had you here before and we are pleased to see you back again. Can I welcome the Minister from the House of Lords in her debut before the Select Committee. We are very pleased to see you here, you are very welcome. Can I begin, Secretary of State, by asking you to introduce you and your colleagues to the Committee.

(*Mr Dobson*) I am Frank Dobson, the Secretary of State for Health. On my left is Baroness Helene Hayman who is responsible for this side of things in the Departmental team and also leads for us in the House of Lords. On my right is Martin Staniforth who has been responsible for producing a large amount of documentation, the vast majority of which is readily understandable and therefore very welcome from the Department.

906. Can I begin by just exploring some general points on the Government's view about the independent sector and its relationship with the National Health Service. How do you view that relationship? How do you view the role of the private sector and the independent sector within your role as Secretary of State for Health?

(*Mr Dobson*) Clearly, the Government's principal responsibility by law is to establish and operate a National Health Service which is available to everybody in the country. We are now faced with a situation where the scale and complexity of work that has been carried out in the private sector has grown in recent times and I think that we have some responsibility to patients and potential patients of that sector because the present regulatory arrangements are clearly quite unsatisfactory. They were originally drawn up at a time when there were not very many private acute hospitals and most of those that there were did not do anything very complex. There are now rather more of them and some of them at least are doing more complex operations. I think it is no longer satisfactory for them to be treated for regulatory purposes as nursing homes. Health care is a complex and difficult matter,

it is not like buying a tin of baked beans and we have laws to protect buyers of baked beans despite the fact that you can make a reasonable assessment both of the price and quality of the baked beans on your own, we need additional protection for people who decide for their own reasons to buy it.

907. Can I ask you about the issue of the balance between what might be termed the freedom of the individual to use the market and the need to protect that individual? Where do you see the role of Government in respect of that process?

(*Mr Dobson*) Clearly if someone decides that they want to be treated as a private patient then they have some responsibility themselves to make sure that they are dealing with people who are likely to give them good quality treatment but, as I say, because knowing about the treatment and the techniques that might be used or the pharmaceutical products that might be used is a rather complex and difficult thing for a lay person, I think we owe to that group of people some sort of duty to see that the premises are in reasonable nick, that if they have an operating theatre it is a modern and up-to-date one and that it is kept clean, that people are not likely to suffer from low standards of performance and low standards of cleanliness, and we have a duty to make sure that anyone who is operating such a hospital is qualified to do so and that the staff are properly qualified to perform whatever it is that they are being expected to do. I also think we have an obligation to make sure that any given hospital in the private sector is only offering to the public operations and treatment of a complexity that it is capable of safely delivering so that if they have been doing a few bits of plastic surgery they do not suddenly, without the necessary equipment, without the necessary back up in terms of equipment and without the necessary qualifications and experience of staff, suddenly announce that they are doing heart bypass operations.

908. Do you have some mechanism currently—we will get on to the proposals for possible change in due course—whereby the Department is aware of perhaps where some of these problems are occurring where there are difficulties in respect of the areas you have just described?

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Chairman Cont]

(*Mr Dobson*) There is a mechanism but I think it is wholly inadequate because, as I said, the regulatory arrangements are based on the idea that these acute hospitals are nursing homes and what is required of a nursing home is not what is required of a place providing acute services and certainly there have been some severe shortcomings. It was not very long ago that we had an obstetrician and gynaecologist in Kent who had, quite rightly, been suspended from work in the National Health Service because he was injuring large numbers of female patients but who was still literally operating on private patients in private hospitals, in at least one of which I think he had a financial interest at the time.

909. One of the issues the Committee has picked up particularly in relation to cosmetic surgery is the whole issue of whether it is right to allow people to be enticed into undergoing treatment which is very limited in value when looked at objectively. Are there any circumstances where the Government would intervene to protect patients where claims are being made that are very questionable or at the end of the day where the Health Service picks up the tab for repairing the damage done to the patient?

(*Mr Dobson*) So far as I know, in relation to what has been offered to people and whether it is of a reasonable quality and what is being done is safe, there are no what might be described as moderate powers available to those responsible for inspecting under the nursing homes legislation. Their choice is between a nuclear weapon and a feather duster. They can say, "Really we do not think you ought to be doing this", or, "You are not up to scratch", or they can close them down but they do not have powers to do anything in between.

910. The area I am referring to, in a sense, you are not able to address. One of the issues that has come out very strongly in this inquiry is the extent to which we as taxpayers who believe in the NHS are paying for repair work for people using the private sector and things going wrong. You may well have seen an article in the *Sunday Times* of 11 April where they claimed that about 1,000 private patients a year are effectively jumping the intensive care queue. "Many cases result from private hospitals botching operations and then finding that the insurance cover, the facilities, or both are insufficient to make the good the resulting complications. Besides blocking beds, private patients are also costing some NHS hospitals up to £60,000 per year." Is that something that concerns you? Is it something that you have got evidence of? If it is, what are you proposing to do about it?

(*Mr Dobson*) It concerns me at several levels. First of all, we ought not to have a situation where any hospitals are doing things so badly that another better equipped, better staffed hospital has to be called in to put right some job that the first hospital has botched because that is very bad for the patient, whoever is doing it and whatever the cost. That is the first thing that we have got to try to address and certainly the present regulatory system does not do that. In terms of the cost and resource problem which this imposes on the NHS, in a sense it seems a bit of an imposition that the NHS and the taxpayer should have to pick up an additional bill because of things having gone wrong in the private sector but there is,

of course, the contrary position and that is that we proceed on the basis that everybody who lives in this country, broadly speaking, is entitled to free treatment under the National Health Service. I would not want to get into a position where we announced, particularly because some private outfit had let somebody down, that a person was not qualified to have free treatment under the Health Service. There is a dilemma both practical and moral.

911. I am sure we would all accept the point you are making. One of the points that I put to your officials, and you are probably aware of it, when we had our first session with them was that I could not see any great difference between where the situation I have described has happened and the person was insured through BUPA or PPP or whoever and something had gone wrong with that course of treatment for which they had been insured. What is the difference when the NHS picks up the tab for the cost of that from the situation of a patient who is driving a car and has a car crash and the state claims back from the car insurance company? It seems a similar situation to me. Do you see any distinction?

(*Mr Dobson*) There may be a bit of a distinction but, as you know, the Law Commission has proposed that in effect anybody who is insured and gets some compensation in almost any circumstance should be treated in the same way that we have, at least in theory, treated road accident victims who have got an insurance settlement since the 1930s. We are still considering that.

912. Before some of my colleagues come in can I just raise one other point about—

(*Mr Dobson*) Maybe I should go on to say that I do envisage in the distinct separate regulatory body that we envisage for private hospitals that one of its duties will be to identify whether each private hospital has the capacity, either its own capacity or an arrangement with the National Health Service, to deal with things when they have gone wrong. I can remember a few years ago there was a proposal to build a private hospital on what used to be referred to as the Odeon site next to University College Hospital and I always remember being rather startled that towards the end of the promotional brochure for this proposition there was a paragraph which said—I paraphrase—"by the way, if anything goes wrong you are just down the road from one of Britain's leading teaching hospitals". It was a big selling point.

Mr Gunnell

913. I do think that there ought to be some mechanism. It is obvious that we have got to treat the person if they need treatment but I do think there ought to be some very clear way in which we could recover the cost from the private sector by going to the insurer. I do believe that the private sector should be responsible for the payment of the cost of those which go wrong as a result of private sector treatment. Furthermore, I believe the private sector, and certain people have made it clear, would welcome regulation. The costs of regulating the private sector, in so far as you can draw up a set of costs, ought they not to be fully funded by the private sector itself?

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Mr Gunnell Cont]

(Mr Dobson) I have some sympathy with the point you are making. You can envisage all sorts of definitional problems. Supposing somebody is treated in a private hospital and then they have a heart attack a couple of days later in the hospital or even when they have gone home, you could then get into some litigious dispute with the insurers and the dispute itself costing a fortune. The last thing I want to do is to put any health service money in the hands of the lawyers. So we have a long dispute as to whether the heart attack was in any way connected with the operation or whether it was something that just happened to happen at that time. I can envisage practical difficulties.

914. I accept there will be some cases where it is difficult to sort out when patients have been transferred as to who should be regarded as responsible for what happens but I would have thought in principle the bulk of the costs of regulating the private sector should be borne by the private sector and the bulk of the costs of clear repairs carried out by the Health Service should be able to be charged to the private sector insurers.

(Mr Dobson) It is certainly my view, and the Government's view, that the cost of regulating private sector hospitals should fall on those hospitals or their sources of finance.

Dr Brand: Secretary of State, can I say from the outset how much I welcome the advance of the Government's thinking on the need to do something about the private sector over the last 18 months. When I had a response about 18 months ago on how we dealt with this sort of control it was all relying on the registration and discipline of individual practitioners. Clearly we now recognise that it is the institution or the marketing or promotional organisation that attracts the private work that also has a responsibility.

The Committee suspended from 4.17 pm to 4.27 pm for a division in the House.

Chairman: Peter Brand?

Dr Brand

915. Secretary of State, you said something very interesting, that the Government's main responsibility was to run the National Health Service. I would accept that if you said it was your Department's main responsibility but clearly the Government's main responsibility is to look after the safety of its citizens in health care whether they are being looked after by the National Health Service or in the private sector. I cannot quite understand why the emphasis is being put on the distinctiveness and the need for a distinct regulatory system for the private as opposed to the public sector health services. If I can use an example or two. Hospices are technically in the private sector, the voluntary sector. We have got voluntary sector service agreements with organisations like Relate, Mencap, alcohol treatment services. We have NHS paid for patients in private nursing homes. We have private patients in NHS hospitals. If you are going to have two sets of regulators it is going to be quite crowded in individual wards at times if something happens. Could you explain why you are exploring this distinctiveness?

(Mr Dobson) There are two things. I think we can distinguish between the responsibility of the Government to provide some protection for individuals who decide to pay for their health treatment and the responsibility of the Government to provide a health care system for everybody. I do not think there is anything to be gained in debating the minutiae of that distinction. All we can possibly do is to regulate the private health care system but it is our responsibility to manage the National Health Service. There is a clear distinction there. I am a great believer, generally speaking, in horses for courses. I am in favour of having organisations which are specific to the task that they are expected to carry out. The proposals that we have come up with for Commissions for Care Standards to deal with nursing homes and other social care are designed for that task and it is intended that there should be one in each region. We are establishing the Commission for Health Improvement (CHIMP) which has specific tasks in relation to the managed NHS health care system but it is not designed to carry out the regulatory functions that need to be carried out for the private acute sector. You could argue that the regional Commissions for Care Standards could each carry out the special regulatory functions that are needed in relation to acute health care but there are some regions that do not have very much private treatment in their area anyway so they might be a bit light on the expertise. I think the least we can expect is that there is a very substantial task for the Commissions for Care Standards dealing with what they are going to be taking on or what we are proposing that they take on, as we spelt out in our White Paper on Social Services, and that will be very extensive because it is not just going to be residential care that they cover, they are going to be responsible for assessing the quality and raising the quality of domiciliary care provided by social services as well which is new and they will be independent. My own view, therefore, is that the best thing we can do is to establish a horse for this particular course which is a regulatory body with the necessary powers to register and deregister with rights of entry, rights of access to documents and so on that would deal specifically with this specific task so that we would have three purpose-designed organisations, the regional Commissions for Care Standards designed for their purpose, CHIMP designed for its NHS purpose, and I do not know what it would be called but the separate regulatory body for the private acute sector designed for that purpose. Otherwise, we could get a situation where, while I do not know which way it would go where either the private sector did not get as much attention as it needed or it distracted the attention of the organisation into spending more time looking at the problems of the private sector and things going wrong there than they did for the National Health Service or social services.

916. So your proposals are based on practicality rather than dogma is the wrong sort of word to use. I am still slightly confused because you are talking about the acute private sector. One of the current problems that we have found is that there is a lot of private activity that does not appear to be regulated at all because it does not fit a description, it is not acute surgery, it is not lay counselling, it is activity

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANIFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Dr Brand Cont]

that can have profound effects on people's health which does not appear to be regulated. I am slightly worried that we are not going to have an overarching organisation to pick up the bits that are missing. You have recognised this problem in the care commissions which, after all, will be responsible for publicly-managed services as well as privately bought-in services by the public sector as well as people paying their own way in residential care. You have accepted there that you needed an over-arching body to look not at who provides but the services that are being provided and I am very surprised you have not taken the same direction as far as the more acute clinical side of things is concerned.

(*Mr Dobson*) I understand the point that you are making but I simply do not agree with you; it is as simple as that. I think it is perfectly sensible to do what we are proposing to do for the Commissions for Care Standards and equally sensible not to divert the activities of CHIMP, which is purposely designed to carry out functions in relation to the NHS into doing something else.

Mr Walter

917. I want to pursue this point a little bit further if I might, Secretary of State. Nobody is under-estimating the complexity of this. You spent a lot of your earlier remarks talking about the acute private sector. The private sector, as Dr Brand has just pointed out, includes nursing homes which you have dealt with in terms of regional Commissions for Care Standards which will look at them whether they are in the private sector, public sector or voluntary sector. They also cover the mental health area which is another area we will get on to later and also the whole area of cosmetic clinics that can turn us all into wonderful beings that we would like to look at. I want to come back to the acute private sector and this question of regulation and why you are going to look at it or want it to be looked separately. There is a precedent for having a body that looks at both the private and public sector in education—OFSTED. CHI's role will be not unlike OFSTED's role in going into state schools and private schools and laying down the same criteria as to what is good practice, what is good service, what are the correct outcomes and so on. It does seem to me that we are perhaps under-estimating what you should be providing for the vast majority of patients in the National Health Service if you do not have the same body dealing with both the acute private sector and the acute public sector.

(*Mr Dobson*) Again, I understand the point that is being made. It is simply that I do not agree with it. I think that the proposition that we are putting forward—and we will be putting this forward in a consultation document which is at present being cleared with my colleagues from other departments and should be coming out very shortly. However, I certainly do not think I have a monopoly of wisdom in this sphere. I do not think even the excellent Mr Staniforth would claim that! We will no doubt get all sorts of representations and in particular representations about where boundaries might be drawn. My own feeling is that we would do better with a specific body with responsibility for

registration and regulation because we do not have a system of registering and regulating NHS hospitals because they are managed by the Government in the first place. And I do not think we should have such a body. I do not think there is any need for any more bureaucracy to be introduced into the Health Service.

Chairman

918. Picking up Robert's point, I do not agree with him on this but for the sake of exploring this angle what about the situation where, as we have seen, patients do interchange between the sectors on a regular basis possibly in one course of treatment. We have got examples where things have gone wrong and it has been difficult to work out where the actual problem has occurred. If your mechanisms are separate which is what you are saying—and I would broadly agree with you although we are still looking in detail at your conclusions obviously—if you had the separate structures you are talking about how would you go on where patients do switch around between the two sectors? You could even have three sectors: the private sector; the independent sector; and the NHS.

(*Mr Dobson*) I do not deny that there might be difficulties arising there but I am not sure having one body looking at all aspects would necessarily get all that much closer to the clinical facts than the arrangement that we are proposing. The object of the exercise, of course, in the end is not to identify people who get things wrong, the object is to have a system in place where far less goes wrong than is going wrong at present which is certainly what we are trying to do with the National Health Service and I think what we are proposing ought to help bring that about in the private sector as well.

919. Minister, did you want to come in on this point?

(*Baroness Hayman*) All I wanted to say is I think the Commission for Health Improvement is one element in a whole system approach to quality in the NHS and the Secretary of State has other mechanisms, the establishment order for a trust to start off with, the appointment of chairmen and non-executives to the board which is responsible who have accountability to him, and he has powers of direction in the last resort after a system of clinical governance inspection by the Commission. If you are going to produce a whole system approach for the private sector you have to recognise that you are dealing with a very different animal. That is why I believe it is more systematic to have a separate regulatory body that has responsibilities for registration and for inspection and for monitoring and, if necessary, for sanctions which actually gives a better guarantee of protection for the consumer of those services.

Mr Walter

920. I just want to come back on this because obviously the personnel involved in the acute sector, the doctors, are working in both sectors, therefore they may be working to different sets of criteria. I wonder whether you would see any role for CHI in

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Mr Walter Cont]

setting standards for the private sector, whether CHI has any role in the private wings of National Health Service hospitals, whether CHI has any role in the services that are provided in the private sector which are bought by health authorities and primary care groups?

(Mr Dobson) To deal with things in the opposite order, first of all it is our view that the National Health Service should have a responsibility for all patients being treated in NHS hospitals, whether they are private pay bed patients or not, so they would be covered by all the machinery of the NHS. We certainly believe that if the National Health Service places a National Health Service patient in a private hospital then all the arrangements for securing quality treatment should apply to those patients. The other point I would make is nothing that the National Institute for Clinical Excellence does will be secret. The guidance issued to the National Health Service, none of that is secret. The activities of the Commission for Health Improvement will not be secret, the material that they issue to the National Health Service will be freely available to the public. The National Service Frameworks that we intend producing to cover particular conditions or particular groups of patients, all of those will be public documents. There is absolutely nothing to stop the private sector making use of them and using them as bench marks for judging at what level they should pitch their provision of services. All of that will be available and they can draw on those as they wish.

921. If I can come back to something you just said, you said if the National Health Service is buying services from the private sector the patient has an expectation that they will get the same standard that they would have got from the National Health Service.

(Mr Dobson) Yes.

922. Which implies that if that standard is set by CHI, CHI would have a role in setting standards in the private sector where they are supplying services to the NHS.

(Mr Dobson) The whole machinery of the National Health Service as we envisage changing it will be responsible for setting and monitoring and delivering a high standard of care to anyone who is an NHS patient wherever they may be. The bulk of that, despite all the organisations like NICE or the National Service Frameworks or CHIMP, will be delivered as ever through the management and clinicians of the Health Service on a day to day basis.

Julia Drown

923. My question arises from the NHS establishments who are concerned that the private sector can set up an establishment as a loss leader or can cherry pick a particularly cheap test or operation that is very easy to provide. This might affect any sort of service; pathology labs or special rehabilitation services to just take two examples. That loss leader can very quickly make the NHS service unviable and then once that NHS service has closed down the private company can put its prices up making the cost to the NHS in the long run much more

expensive. I wonder whether you think there should be any controls on the private sector to prevent them acting in this way or whether there should be additional controls on NHS Commissioners to prevent this difficult situation arising?

(Mr Dobson) As the National Health Service is generally speaking considerably more cost-effective and efficient than the private sector it will normally be able to offer services that are cheaper than the private sector. If the commissioning body is looking for the best quality and best value for money it is more likely to get it from the NHS than it is from anywhere else. Certainly we have issued advice to people in the NHS that they should try to make sure that they have checked that no other NHS services are available before they resort to buying services in the private sector. Generally speaking the situation you are describing will not arise. Certainly it does appear that the private sector is in some difficulty because while the NHS has a bed occupancy rate around 90 per cent, quite a lot of the private hospitals are around 50 per cent. This is a rather expensive business for them and it is one of the reasons why some of the organisations are trying to encourage—I think that is an understatement—trying to get clinicians to get people referred to private hospitals rather than pay beds in NHS hospitals.

924. Is there not a problem that the financial rules of cost in the NHS mean that the full costs have to be recovered on any particular test or operation whereas the private sector is free to run a loss leader, or not even necessarily a loss leader, as in the medium term they can cover their marginal costs plus a bit, and that creates an uneven playing field between the two sectors?

(Mr Dobson) I think that may arise from time to time but as far as I can see it is not a particularly general problem.

Audrey Wise

925. I have just been reflecting on Robert Walter's questions and your answers, Secretary of State, and thinking about Lady Hayman's systematic approach and trying to visualise this position with CHI, or CHIMP or whatever. I appreciate you say that the standards and things that they publish will be public documents. Suppose we have a system for the private sector as you envisage, do I gather that it would be quite open to those running that system on behalf of the Government to say "CHI's standards or guidelines need to be followed" either in a general way or in an issue by issue way after deciding whether they are, in fact, appropriate in the private sector? Would that be the kind of link which would be permissible, so they would not need to keep reinventing the wheel?

(Mr Dobson) Certainly at this time I would not want to lay down any rules as to where the proposed new regulatory body got its expertise from or what standards it used but it would be simpler all round if they did attempt to apply the standards, and I think it would be simpler for the private sector, that were being applied in the National Health Service. After all, the vast majority of surgeons carrying out surgery in the private sector spend most of their time carrying

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Audrey Wise Cont]

out surgery in the National Health Service so it would be better if they were used to applying the same standards in both places.

926. So there could be a separate regulatory system but it would still draw on the work being done by CHIMP where it was appropriate?

(Mr Dobson) Yes.

(Baroness Hayman) I think there is an analogy as well with professional self-regulation, for example GMC registration which applies across both sectors. One of the conditions for registration for a private sector establishment would be registration of those working with the appropriate professional bodies which is across the board. So it is drawing on one set of expertise but it is the implementation mechanisms.

927. So it is separate but it is not necessarily self-contained.

(Baroness Hayman) It would be silly to set up professional self-regulation for those who work in the private sector separately from those who work in the NHS because they are often the same people, so you take the national standards, if you like.

928. The same principles could apply to the new bodies being set up, yes, thank you.

(Mr Dobson) Which I think augments our case for saying that we need a body which is predominantly regulatory that registers and lays down conditions in regulations and licences rather than one which carries out other wider functions. It needs to be basically a regulatory organisation which is not a function of CHIMP.

Mr Amess

929. I would not want to misrepresent your position—

(Mr Dobson) Yes you would!

930.—But I got the distinct impression that since you have been responsible for the stewardship of the National Health Service that you are not terribly keen on the private sector and independent health care. Is that an accurate perception I have formed of yourself?

(Mr Dobson) Personally I would like to think that the National Health Service was capable of providing all the services that anybody reasonably wanted in our society and I would like to think that the measures that we are introducing now will move us toward that. If people want to pay out good money to get services which cannot possibly be any better than the National Health Service because they are being carried out predominantly by people who work in the National Health Service—and I cannot imagine doctors would provide two different qualities of service, it would be quite unethical to do so—I cannot understand why people do it but they choose to and I think they are entitled to have some regulation to protect them.

931. Thank you for that straightforward answer. If the Chairman gives me some time later I may come back to it. Do you believe that the independent sector are sincere in their view that they want to be regulated?

(Mr Dobson) Yes I think they see it as a form of protection because I think some of the incidents which have happened have damaged their reputation and their prosperity depends on their reputation and to be able to say that they are rigorously regulated is therefore advantageous to them. So I am sure they are being perfectly straightforward about it.

932. I thank you for that and certainly some of that came out in our evidence. I know you are not going to have this in front of you but in Hansard on 18 January there was a debate in column 603 and there was an exchange between yourself and Miss Widdecombe. She said: "I am on record as having said for some time that the private sector should be regulated. If it is to play an expanded role it must be regulated. I have called on the Secretary of State to consider that because those in the private sector tell me that when they raise the issue with him he will not meet them because he says that he is nothing to do with the private sector." Hansard then says your reply is: "They are liars."

(Mr Dobson) Yes, that is right.

933. Again I thank you.

(Mr Dobson) Hansard is correct!

934. Again, I thank you for clarifying that position. I have some correspondence with me showing that when one of the people involved in the provision of health care tried to get a meeting according to them one of your officials responded that you could not find time to meet this health care organisation as "... his fundamental responsibility is to support and improve the NHS. He is unable to give any priority to partnerships with the independent sector." Is that your case?

(Mr Dobson) No, I do not think that is a reasonable presentation of my position. I do not know when that letter was written—

935. I know a meeting was held with your parliamentary colleague.

(Mr Dobson) Exactly. The people from the private sector have been seeing other members of the team. They have been seeing officials and at the time Ms Widdecombe was denouncing me for not paying any attention to the need to regulate the private sector, she appeared to be in total ignorance of all the work that had been done in preparation of the documents which we will be issuing shortly. You must ask her why she said what she said, not me.

936. I fully intend to and you would expect me to defend my parliamentary colleague against the charge of being ignorant; I find she is quite the reverse. I am on the Committee of this dreadful Bill that we are scrutinising at the moment and I want to refer to the point that my colleague mentioned earlier because during the second reading of the Health Bill you said that the independent acute sector certainly needs to be properly regulated but that the Commission for Health Improvement—this ghastly CHI, CHIMP, NICE and all the rest of it, for goodness sake I hope we can find other descriptions—is not designed to do the job. From what is going on in Committee Room 11 it seems to me the only reason why the Commission for Health Improvement will not be designed to do the job is because it seems to me you are absolutely intent on

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANIFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Mr Amess Cont]

overturning our amendments to the Health Bill which I believe would give you the option to extend CHIMP, its functions and its organisational structure to the private sector in order that it would be tailor-made to do the job. Is it the case that you do not agree that CHIMP in this form is far better equipped to regulate independent acute hospitals than extending nursing homes regulatory system?

(Mr Dobson) I have never contemplated extending the nursing home regulatory system because I think it is inadequate. What I have said several times now is I believe we should have a separate regulatory body. I am rather surprised that you should advocate using CHIMP to regulate anything because I believe that very recently you and your Conservative colleagues voted against establishing it in the first place.

937. I can assure you that we have spent a great deal of time putting that into context. But the final point, following on from a point that you made in response to my colleague's question, and I wondered if your officials might be able to pass you answer to this, is how many intensive care admissions are there from, if you like, botched operations in the National Health Service which are being dealt with now by the private sector? Do you have those statistics?

(Mr Dobson) No I do not have those statistics. There are a few but as there are actually very few intensive care beds in the private sector it seems fairly unlikely that there are a large number of people moved into intensive care beds from the National Health Service although that does occasionally happen.

Mr Amess: Thank you.

Chairman

938. Can I just pursue a bit further the issue of professional self-regulation and clinical governance as it relates to the private sector. The BMA, as you probably know, in their evidence to us argued for the importance of the medical advisory committees within the private acute sector. What are your views on the role of those committees in the context of regulations and standards?

(Mr Dobson) For a start the professional arrangements and self-regulation and responsibility to the General Medical Council apply to doctors wherever they are working and that should certainly be the case. It has been my view since I have had this job that the National Health Service as an institution has made little or no contribution to helping professionals raise standards and maintain standards as they would wish to do and that is why we have established NICE, that is why we are establishing CHIMP (providing the Opposition do not muster a majority in the Committee and vote against it again) and that is why we are establishing National Service Frameworks and establishing the concept of clinical governance within the National Health Service to augment and supplement the efforts that professionals make to raise and maintain standards. So I welcome any arrangements that the private sector has with the professionals to, again, set and maintain and raise standards in the private sector, but whatever else they do I do not think that they could possibly be regulatory organisations because

that would be a different form of self-regulation—not professional self-regulation but regulation of institutions which is a different matter.

939. So you see the role for the Medical Advisory Committees within the independent sector in this respect. How would they be accountable within your framework? Secondly, do you see any occasions when compared to the NHS there may be some conflicts of interest within the Medical Advisory Committee in the context we explored with the BMA, the kind of issue where perhaps it is difficult to illustrate there is a conflict between the commercial interests of doctors and the clinical standards side of the work they are doing with this Committee where maybe they have got anxieties about a particular doctor undertaking certain treatments that are dubious in quality and yet that is an important element of the commercial interests of that establishment? Do you understand the point I am making?

(Mr Dobson) Yes. Helene has been doing work on the Medical Advisory Committees.

(Baroness Hayman) I think it is a good illustration of the difficulty of laying down delivery mechanisms in a sector that you are regulating rather than managing. It is possible within the NHS to say we want a system of clinical governance that is delivered in every NHS organisation. The Medical Advisory Committees in some parts of the private sector have performed the role that the Medical Director, which was again a statutory appointment of a trust board, has provided within the NHS. I think we have to step back and look at the conditions for registration which will have conditions about appropriate mechanisms for ensuring quality of clinical care, but then it has to be for the institution to fulfil those conditions in the most appropriate way. This is where we get into the difficulty of managing at arm's length by saying "you must have a Medical Advisory Committee and it must be accountable to me, the Secretary of State", when the Secretary of State is not the employer and is not the person who is responsible for the care that is being provided. That is why I think we have to be very clear about what the objectives and the conditions for registration are but not the mechanisms. Then the regulatory body would also have to make sure the framework that was in existence was not compromised by the sorts of issues that you are talking about.

940. You accept that those compromises could happen on occasions. The question I am putting to you is within the broad framework that you are looking towards, and I accept you cannot be too prescriptive because this matter is still being looked at, where would the checks be on what is happening internally within the Medical Advisory Committees if one went for the BMA model?

(Baroness Hayman) There is a danger of going too deeply into the BMA model. I step back again from that and say that it is important that potential conflicts are recognised in advance so that the framework that is set up is one that ensures both in registration and in monitoring that they do not occur. I imagine that would be one of the areas in which any regulatory body would take an interest.

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANIFORTH
AND BARONESS HELENE HAYMAN

[Continued]

Audrey Wise

941. Our inquiry is multi-faceted because the private medical sector covers a great range of different activities. One of the things which prompted some of us to take an interest in this was particularly connected with the field of cosmetic surgery. I appreciate that there may be cross-boundary issues between yourself and colleagues and that my first question might impinge on that, but no doubt you talk to your colleagues anyway. The first question is about advertising and particularly cosmetic surgery advertising. It is quite clear that there is a particular vulnerability with some of the people who consider cosmetic surgery and it has been drawn to our attention that the regulatory system through the Advertising Standards Agency might not be really adequate when it comes to dealing with cosmetic surgery. You yourself did point out the difference between tins of beans and medical care. Have you given any thought to the question of advertising which might impinge on both the practical results and might result in somebody being scarred or having psychological scars? Have you given any thought to the place of advertising and whether it is sufficiently regulated on this issue?

(*Mr Dobson*) My own view of that is that providing we can deal with the regulation of the treatment then probably the advertising side of things, which is related to protecting anybody who may read an advertisement that is offering any goods or services, ought to be appropriate. One of the reasons why the Government has a special obligation to people who are seeking health care of one sort or another is that it is rather difficult for people to be able to make a judgment that certain standards will be met. I guess if you are really pernickety before you ate in a restaurant you could actually look around a kitchen. If you go into a hospital you could even look around the operating theatre but you would not know whether the team who were going to operate on you were up to it or not. In the peculiar circumstances of medical treatment we have a special obligation to the public to make sure that reasonable standards are set. I would hope that if and when we achieve that then the question of misleading advertising could be dealt with just as for misleading advertising for anything.

942. Do I gather from that that you are contemplating ensuring that there is more attention paid to making sure that people who do cosmetic surgery, along with other things, are actually appropriately qualified for the particular things they do? At the moment they have to be qualified but it is a very moveable feast. Have you got in mind to do something about it?

(*Baroness Hayman*) Whether or not you have got registration would depend on fulfilling a range of conditions which would include appropriate qualification for the procedures that were being undertaken. As well as clear advertising there is an issue about information for patients, information both on outcomes and performance of an individual institution, which we are moving to within the NHS, which I think those who use the private sector ought also to have some information about. There is information about particular procedures. We have been looking at this in the case of breast implants,

about the information that ought to be available for every woman regardless of what she sees in the advert before she makes a decision about what she is going to do, the quality of that information. Obviously if you had a process of regulation and inspection it could ensure, for example, that patients were receiving appropriate information about the procedure in general and what went on in that institution as part of the conditions of registration. That is an example, and one might not go specifically for that in the broad outline, but it is the sort of area that I would think it is important to cover so that people do know what they are letting themselves in for.

943. I notice that the advertising design, much of it in this area, seems to convey two separate messages. One message is that this is very important to you, it can make an enormous difference, it can help your relationships, etc., and as Robert said it can make us all feel that we can be very glamorous or attractive or whatever, and at the same time another message is that actually most of the procedures are rather trivial and not dangerous and you need not worry. It was expressed in particular when one of our witnesses said "There is a continuum between the cosmetic industry and cosmetic surgery, it is all about improving appearance". I did confess that I wear lipstick and I did confess there was a time when I wore false eyelashes but I never thought that had any relationship whatsoever with cosmetic surgery. It seems to me this continuum approach is dangerous and does distinguish it from other kinds of advertising, it goes to the heart of people's identities.

(*Mr Dobson*) I think as Helene has been saying, amongst the things that we envisage the regulatory body doing, not just for the, as you have said, particularly difficult area of cosmetic surgery but generally, is to ensure that the potential patients and the patients have accurate information available to them about the risks and possible problems and presumably possible advantages of having the treatment that is offered. They are checking also that the clinicians who are going to carry out the treatment have the necessary qualifications and experience.

944. It was brought to our attention that sometimes the Advertising Standards Agency does find against particular adverts but then they appear again and again after such a judgment, even for 18 months. Do you think that either your Department or a more appropriate Department, if there is one, should look at that very specifically, especially for such serious topics?

(*Mr Dobson*) It does seem to be more a matter for, I think it is the DTI that is responsible for advertising.

945. Yes, I think so.

(*Mr Dobson*) It seems to me if there can be a finding against someone and then they persist there ought to be some measures to stop them, certainly in this sphere.

946. Leading on from that, some of the things which are done in connection with people's appearance in particular involve very new technologies and we have had evidence and we have made visits to where these things are being used. For

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Audrey Wise Cont]

example, laser treatment, laser treatment used to remove tattoos, used for all sorts of things and very powerful technical equipment in many cases.

(Mr Dobson) Yes.

947. To our astonishment we found that was also something that was regulated under the Registered Homes Act.

(Mr Dobson) Yes.

948. We took informal evidence from Professor Roland Blackwell who actually is an inspector for a health authority inspecting premises using lasers. He painted an extremely alarming picture of the low standard displayed in these premises: wrong equipment, even to little things like never the right goggles for the operators and all sort of things. The majority of his inspections show shortfalls and when we asked: "But will this be corrected next year?", he said: "No, this is year on year". Each year his inspections show similar things.

(Mr Dobson) Yes.

949. Would this be the sort of thing that you would want to put right? Do you feel the Registered Homes Act is appropriate?

(Mr Dobson) No, it is certainly totally inappropriate for the use of that sort of technology on a human being, I do not have any doubt about that, and we would expect it to be properly covered by our new arrangements. If people think of other spheres which might appropriately be covered which are not spelt out in the consultation document when it comes out, we would be prepared to listen. The point I made to the Chair fairly early on is that at the moment the inspectors and the inspecting body cannot lay down conditions. They can either let them continue or close them down, there is no intermediate measure that they can take.

950. We further found that there is equipment which is not controlled at all, which is short of laser but has some resemblance to the lay person anyway, high intensity light sources for example.

(Mr Dobson) Yes.

951. We visited premises where this was in use and we found that although in those premises it was operated by a doctor there is no actual legal requirement for that and the whole control edifice depends on the manufacturer. At the moment the manufacturer does not sell it to people who are not medically qualified but there is nothing in law to stop it. There is actually equipment which is used by non qualified people which has potential danger and so would this also be exercising your minds? Would you do something about this, please?

(Mr Dobson) As I say, we will bear in mind obviously what the Committee says and we expect to get other representations about various aspects of the consultation document. There is no point in consulting unless we expect people to come up with things that they do not agree with that we are proposing or drawing attention to omissions. No doubt we will be denounced by the BBC for getting the consultation document wrong in the first place but I do not think we should be too vain.

Chairman

952. It seems to be an incredible anomaly in law that the only instruction on the use of the machine is by the manufacturer. I was quite alarmed by that.

(Mr Dobson) Yes.

Dr Stoate

953. Secretary of State, obviously as a doctor you would expect me to take a particular interest in clinical issues and evidence based medicine, which is why I am very pleased that you have announced the setting up of NICE and CHI. Rather than them being a joke I think they are extremely important bodies which I think will further clinical practice in the future. I am also pleased to notice that the Government has introduced a wide range of quality assurance programmes in the NHS over the last 18 months or so but to what extent would you be prepared to impose the same type of framework on the private sector?

(Mr Dobson) I am not sure that would be appropriate. We are responsible for managing the National Health Service and every aspect of it and when something goes wrong I get denounced by newspapers, television, radio and sometimes I get denounced at the Despatch Box in the House of Commons and Lady Hayman likewise in the Lords. That does not apply, and should not apply, to things that happen in the private sector. If there were shortcomings, as there are, if we allowed the present inadequacy of regulation of the private sector to continue, then it would be legitimate to criticise us. As I say, we do intend changing it.

954. On the other hand, if, as you have said, all consultants in the NHS must take part in audit that must be a good thing and I welcome that and I am sure that most consultants and most other doctors would welcome that as well. But, if it is right in the NHS that all consultants should take part in law to ensure that their practice really is delivering the goods, why is it not appropriate to impose that on the private sector?

(Mr Dobson) There is a reasonable case for arguing that but is that a proper role for the Government? If the doctors choose to go in the private sector and the patients choose to go in the private sector, they are exercising their choice.

955. Okay. I am not entirely happy with that because I believe that when you said right at the beginning that the Government role is to ensure to some extent that anyone using the private sector, should they choose to do so, should at least be able to count on some protection from the Government—

(Mr Dobson) Yes.

956.—if it turned out that audit were to show some clinical malpractice surely it would be right for the Government to impose some type of regulation on that rather than just say: "Well, it is not our problem, if you go to the private sector and it is not up to standard, well that is too bad".

(Mr Dobson) No, but I am not saying that, I am saying that there are ways of requiring the people who run a hospital to have the necessary buildings, plant and equipment, dressings, pharmaceuticals and to require the people who are carrying out the clinical

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Dr Stoaate Cont]

procedures to be properly qualified. If the private sector then wants to carry out clinical audit in collaboration with its doctors then it seems to me that is largely a job for them. That is what the Government does in the National Health Service because it clearly is a job for us. Of course, the General Medical Council's responsibilities extend to all doctors operating both in the public and private sector and also, as I understand it, the recent decision of the General Medical Council to introduce a concept of revalidation so that clinicians would have to keep showing at regular intervals that their techniques were up to standard and up to date, and that they were still capable of doing a good job, that will apply both in the private sector as well as the National Health Service. The various changes that are being brought about I think ought to provide the degree of security that outside regulation and outside professional self-regulation can deliver.

957. You have already said that it is okay for somebody to judge the content and value of a tin of baked beans but it is extremely difficult for them to judge the content and value of their medical procedures. We have had evidence that shows that certain procedures are carried out more frequently in the private sector than they are in the NHS, for example grommet operations and hysterectomies. It is an arguable case, but there seems to be a higher incidence of those operations in the private sector than in the NHS. Were it to be the case that NICE, for example, said that there is no case for grommet operations in the NHS hospitals and so presumably they have stopped happening and they were to carry on in the private sector, would you consider that a worrying aspect or would you consider that to be something for the private sector to sort out for itself?

(*Mr Dobson*) It is certainly the case that some of the services that are provided by the private sector are not very readily available in the National Health Service and on most people's judgment would not be a high priority, which is one of the reasons why so much cosmetic surgery is done in the private sector. Practically every indication of public opinion on that matter would endorse most cosmetic surgery not being available on the NHS. So if NICE, which would generally be reflecting professional opinion, recommends that generally speaking—because the recommendation will only ever be generally speaking—grommet operations should not be available on the NHS, then if people want to get them in the private sector that is up to them and the people who might offer their services, it seems to me.

958. What would you say if NICE made the point—I am not saying they would—that grommets could actually be potentially more harmful than not doing it? Would you still be happy to let the private sector carry on doing them if they chose to?

(*Mr Dobson*) We are getting into a professional area there presumably where the General Medical Council, the Royal Colleges and such like would be giving their attention to this matter. If there is pretty sound advice that something is dodgy then it ought not to be provided wherever it is. But that is up to the providers. What we cannot have is the National Health Service or the Secretary of State for Health responsible for everything other than the profits of the private sector.

Mr Gunnell

959. You have made out a case for the private sector having its own regulatory system and I think you have also made out the case for them paying for their own regulatory system. I think that that still leaves the Government with the job of ensuring that that system of regulation which they put in place is really a thorough system of regulation and for those who are not properly regulated by that system, I think it is our job to ensure that it does regulate them all.

(*Mr Dobson*) They are not going to put in place a regulatory system, we are going to put in place a regulatory system. It will check on the buildings, the plant, the equipment, it will check on the pharmaceuticals that are provided, it will check on the people who are managing the acute sector provision and it will check on the clinicians who are providing it and those all seem to me to be proper regulatory functions for the Government in relation to a private sector establishment and a private sector service. There is obviously a boundary to be drawn somewhere and we can have discussions about the minutiae of where the boundary should be drawn.

Dr Stoaate

960. Just a final point about the GMC's proposals for revalidation. How will you be able to ensure that the proposals for revalidation really will be transparent to the public and how will you further ensure that they will cover all medical practitioners?

(*Mr Dobson*) Revalidation is a matter which has been put forward by the General Medical Council and the people leading it and they have got the General Medical Council as a whole to vote by an overwhelming majority to introduce revalidation in principle and they have set up a working group or a study group or whatever they call it to advise them on how best to go about it, but that is a matter for the General Medical Council rather than for me. We have and I very strongly believe in a transparent but predominantly self-regulatory system for the medical profession and so I would expect them to come up with proposals which will be transparent and which will work, but certainly the decision that they took was that the revalidation approach would apply to all doctors in whatever sector.

Dr Stoaate: Thank you.

Chairman

961. Can I just explore for a moment or two the development of primary care centres within the private sector. As you may be aware, we did pay a visit to one walk-in GP surgery, which was of great interest and clearly this is an increasing trend. It was a pity that our two GP members were not with us for this visit because I would have welcomed their thoughts on the implications for the NHS GP as a consequence of the development of private general practices because one of the areas that this very thriving private clinic was pushing were treatments that were not likely to be available on the NHS. You talked about the private patient exercising choice and this is a difficult area whereby if a patient exercises choice to go private they can decide that they do not

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANIFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Chairman Cont]

want their own family doctor advised of the treatment within this primary care centre by the private GP. It struck me at the time that that could cause serious difficulties. Viagra is an example. I raised the question, "Well, if you have got a patient who comes in and you prescribe Viagra, is it not appropriate to check that that patient's GP is aware of that prescription and the possible implications for the partner in that relationship that that GP might be treating?" It struck me that there was an enormous anomaly that could occur. I do not know what my GP colleagues' thoughts were, but it struck me that this was hitting at the heart of the NHS patient's rights in a situation such as this. I wondered whether you have got any proposals that would reflect the growing development of that kind of clinical procedure where the NHS GP is effectively cut out?

(Mr Dobson) The consultation document will cover those sort of developments and is asking where people think the regulatory boundary should be drawn.

Chairman: What can you do? Do you feel it is appropriate that a patient says, "I do not want my GP told about this particular treatment" if the doctor in the private clinic is aware that has implications for the NHS GP and his/her treatment of the rest of the family? It struck me as being possibly a quite dangerous situation. Peter, do you want to come in? You understand the point I am making?

Dr Brand: Yes, I think there has been a real practical problem with slimming clinics prescribing amphetamines and then not letting general practitioners know. I think that is actually malpractice, frankly, not involving the other practitioner because the first time you hear about it is in the middle of the night when people have funny turns.

Chairman: You are saying it is malpractice in those circumstances for the private GP not to notify the NHS?

Dr Brand

962. The prescribing is doubtful but it is the fact you then do not inform the other doctor and that you continue with the prescription. The patient is entitled to say "Do not inform my GP" but the private doctor is then entitled to say "In that case I will not prescribe something". That is the only safe thing to do. I am afraid that is not happening. The real weakness of the system we have got at the moment is that the General Medical Council really does not want to know about that sort of relationship and those dangers and the institutions employing the doctor, although they are normally self-employed, say it is not their problem, it is a clinical decision. It is very dangerous.

(Mr Dobson) There is an ethical dilemma, is there not? One is the ethical obligation to look after the interests of the patient by informing the other doctor who normally looks after their interests, but then there is the other problem about patient confidentiality.

Chairman

963. Minister, do you want to respond?

(Baroness Hayman) Yes, I was going to make the same point as the Secretary of State. The same sorts of dilemmas are raised in family planning clinics, GU clinics and a whole range of services where patients may seek confidentiality and may seek deliberately to avoid knowledge that would be best passed, an outside observer would think would be best passed, to another professional. That is why I think it is a professional matter to find the right boundaries for reconciling the need and the obligation to transfer information and the circumstances in which that is justified and would override a request for patient confidentiality. I do think one of the weaknesses of the current regulatory arrangements, which you alluded to in a way, is that they are very much bed based and do not recognise the advances that have gone on that make treatments available that may contain significant risk, and certainly ought to be regulated, to be available in other situations than institutions which operate beds. I think that is one of the issues that a new system of regulation has to address.

964. You make the point that this is effectively about professional standards, about the appropriateness of that doctor's practice, but we could not see any mechanism at all in this particular clinic for checking that. There was no overview whatsoever.

(Baroness Hayman) No.

965. Clearly the GP would not be aware of it. Under what you are proposing I am not sure how that will be checked. You might want to give some thought to that.

(Mr Dobson) Yes.

(Baroness Hayman) I think it is the premises that would be covered by regulation where you draw the line and whether you do include premises that in the past have been excluded.

966. Yes, but with the premises being regulated you would not intervene on that process of doctor/patient. I cannot see any way.

(Baroness Hayman) You would want to have some assurances in the system that there were guarantees of proper supervision of and conduct of the professional staff working within the organisation. That has to be the same concept wherever it is. So I think when you talk about staff, it then gets down to staff who are abiding by their professional bodies' requirements in this area.

Dr Stoate

967. Baroness Hayman, would you not agree with me there is a distinction between somebody who goes to a family planning clinic or a GU clinic and wants confidentiality purely for personal or medical reasons, that is one thing, but when you get a clinic that is doing something for commercial reasons surely that oversteps a line?

(Baroness Hayman) I think that brings in another dimension to it, yes, and it makes the distinction difficult to draw sometimes. It is important that the commercial interests should not distort the same sort of balance of patient interest that would occur in a

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Dr Stoa *Cont*]

situation where it was another NHS practitioner who was being approached. I think the guiding principles have to be not distorted by the commercial environment but some of the situations in which, for example, family planning advice and termination services might be sought, would equally not be NHS situations. I think it is not as clear cut as that.

(*Mr Dobson*) What we do want to do with the machinery that we intend establishing is to make sure that it is capable of keeping up with what might be described as technological change and organisational change, change in fashion for that matter, so that places do not just grow, take on a new role, without being covered.

Audrey Wise

968. Before we leave clinical issues, could I ask you about something which is of deep concern to me arising from evidence provided to the Committee by the Royal College of Nursing. They have drawn our attention to the fact that there is a lot more children now receiving private medical care, that the age range has become much younger, much wider, and they have said some quite serious things, that sometimes the necessary equipment appropriate for children is lacking, not many children are dealt with in a particular unit but there is always a few, that kind of thing, poor recognition and management of pain in children, all the sorts of things that this Committee has given attention to before. Now the issues about choice seem to me to be rather different when it comes to child patients. Could I ask whether in your consultation document you will be drawing attention to this particular aspect to see whether there may be additional safeguards needed or some different safeguards needed? I am not suggesting parents should not have the right to opt but the child is not choosing. It was also drawn to our attention that nurses expressing concern over standards of care of children have sometimes been told "Well, find another job" and in the evidence it said that in September 1996 the Royal College of Nursing and the College of Paediatrics wrote to the Department of Health drawing attention to some of these concerns. So can I ask you to root out that correspondence and perhaps give some fresh consideration in the light of this new development of an approach to regulation?

(*Mr Dobson*) I can assure you that the consultation document will cover the question of any special arrangements which may be needed to protect children. The overall approach that if a particular hospital is offering a particular service, in this case to children, then, like with all the other services it may be offering, it will have to show to the regulatory body that it has the capacity in terms of plant and equipment and in terms of qualified and experienced staff, it has the capacity to deliver the services it claims it can deliver.

969. Yes. I would feel happier if I was absolutely sure that children would be specifically mentioned. My observation is that in many spheres, including very much the health sphere, children somehow become subsumed into everybody else.

(*Mr Dobson*) I can offer a guarantee. I do not make many promises.

Julia Drown

970. I would like to ask about the protection of professional titles. The Committee is concerned that people can call themselves a consultant even though they do not have medical qualifications and there is a number of other similar titles which lay people would think meant people had health qualifications. We are aware that the Government is currently looking at the legislation on Professions Supplementary to Medicine and wanting to protect titles further there. Would you want to extend that need to protect titles to cover all areas of clinical and health care? The Committee would like to know how you can prevent new bogus titles then cropping up in the future. This leaves people very vulnerable when they think they are talking to somebody medically qualified and they are not.

(*Baroness Hayman*) I think the issue of protection of title is one of the most important ones for ensuring patient safety. It is particularly pertinent, perhaps, to use the example of chiropody in particular, which does not have protection of title to protect it. The NHS has mechanisms for ensuring that only registered chiropodists are providing the care in the NHS. The mechanism is not there for somebody just calling themselves a chiropodist and providing services elsewhere. Protection of title would provide that. It is one of the reasons for the desire to update the Professions Supplementary to Medicine Act. There are other professionals who are looking for professional regulation in order to protect titles. Some titles are particularly difficult like doctor because of the use of other doctorates than medical doctorates and there are some areas where I think particularly new professions are looking at whether they should go for a system of self-regulation that also brings in the protection of titles and there is an issue about psychologists. I think the other big area is in support workers and what you would do in terms of regulation of that, regulation of the professions, which again sometimes brings in the issue of protection of title, but I do think the Health Bill gives us a mechanism for taking action across a range of professions through secondary legislation which will be much more effective than we have had in the past.

971. So the Department's aim is to ensure that all titles are protected or will you be leaving it to the professionals to decide for themselves?

(*Baroness Hayman*) Protection of title is one element in protection of the public that comes from effective professional self-regulation and I think you have to look at each individual profession and what they need to do to strengthen the protection that they give to the public. In some areas protection of title will be particularly important and it is certainly particularly important to the Professions Supplementary to Medicine.

Mr Lewis

972. Secretary of State, I hope you will bear with me while I cobble together my own question. I have not got the benefit of a Conservative research department advising me or Millbank or anybody else for that matter.

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Mr Lewis Cont]*(Mr Dobson)* You may be at an advantage!

973. I want to deal with the issue of complaints. We have met a number of very troubled ex-patients and relatives of ex-patients in the independent sector who have had great difficulty in having complaints dealt with satisfactorily. We have had evidence of people being passed from pillar to post in terms of responsibility, from clinicians with admitting rights to the management of hospitals, to the insurers, but nobody willing to take any responsibility for dealing with very real complaints. I just wondered whether you had any plans within the consultation document to deal with this whole issue of having satisfactory, transparent, clear complaints procedures?

(Mr Dobson) Yes, we would propose that the regulatory body would make getting a licence conditional on them having a proper and effective complaints procedure.

974. So that would be a stipulation. Would you see any role for extending the remit of the NHS Ombudsman to look at complaints arising from treatment in the independent sector?

(Mr Dobson) It is not a decision for me, but I personally would not. It seems to me that the NHS Ombudsman is somebody who is responsible for looking into things that happen in the public health care sector. There are Ombudsmen who look at the private sector in some cases, but to the best of my knowledge there is not currently a hybrid and it would be a rather strange situation to extend a public sector Ombudsman to cover the private sector.

Mr Lewis: Thank you.

Julia Drown

975. My question is about the issue of consultants who have been suspended from the NHS. We have had some interesting discussions with other witnesses on whether consultants suspended from the NHS should be able to practice in the private sector. What are your views on that?

(Mr Dobson) The answer is no.

Chairman

976. But they can currently.

(Mr Dobson) They can currently, but my own view is no. It depends on why they have been suspended, but if they have been suspended for anything that could have any possible bearing on the safety or health of patients then it seems to me that we need a system in which people should not be able to operate literally in the private sector.

Julia Drown

977. Perhaps I could be devil's advocate for a minute. One of the responses we have had when we put that to witnesses is that somebody who is a consultant in obstetrics and gynaecology could be suspended in their obstetric practice but there have been no problems with their gynaecology practice. Should they not be able to continue in their gynaecological practice in the private sector?

(Mr Dobson) I have to say, I would tend myself to say no.

978. Are you going to do anything to stop that happening?

(Mr Dobson) Yes. We would intend that the regulatory mechanisms would—it would not just be the regulatory mechanisms. We would have to have in place a system whereby the regulator and private hospitals were informed that someone had been suspended.

Chairman

979. You and I had a conversation earlier this week about a particular set of very complex circumstances that you are familiar with and I am in my area where the issue of continuing to practice in the private sector was a factor. Where you have got complications in respect of legal action being taken in a situation, without going into the detail of the case we are talking about, how could you get a system that will protect people within the private sector or are you assuming there will be an agreement among the private providers to have some arrangement where if there is a problem of the nature we were talking about that would stop their practice immediately?

(Mr Dobson) This is a matter on which we will be consulting. We may end up with a different policy in the end, but my own view would be that if someone's clinical performance is sufficiently bad to be suspended for clinical reasons from operating within the National Health Service then I do not really see any reason why the regulator and the regulations should not say that they cannot operate in the private sector until that suspension and any disciplinary proceedings or GMC proceedings have been completed.

Julia Drown

980. It is a difficult issue. I think many of us would have much sympathy with what you are saying. The other thing people have said is that, of course, suspension in the NHS is supposed to be a neutral process while it is being investigated, so that creates one difficulty, but for their NHS work they are suspended on full pay, whereas in the private sector suspension deprives these people of any income. If you were going to change the regulations so they could not work in the private sector, how would you avoid being sued for compensation for loss of income in the private sector?

(Mr Dobson) I think we could change the law and introduce a regulatory system in which they would not be so entitled. I think we could get round that fairly straightforwardly. In the B-movie you get the gun-slingers saying, "We deal in lead". Well, in this place we deal in laws.

Audrey Wise

981. Do you not think, Secretary of State, that there would have to be a good deal more rigour in the suspension process than seems to exist at present? I can think of people off the top of my head who have been suspended quite unjustifiably as it has turned out. In fact, I can think of two female obstetricians

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANIFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Audrey Wise Cont]

who were prevented from practising for a considerable time, one of whom subsequently became a professor.

(Mr Dobson) I can think of the same person. She was not noted for her work in the private sector as I recall!

982. Exactly. The principle is there. I think there would be general agreement were it established that somebody is an unsafe practitioner, but suspension is not about that and that seems the problem.

(Baroness Hayman) We are looking at the whole suspension process, which is unsatisfactory at the moment and looking at ways in which we can improve that and we have to make sure that people are only suspended on the grounds of being a danger to patient safety when there are good grounds for that, but when there are good grounds for that we have to ensure that anyone who might be employing them knows about it and takes appropriate action to protect patients.

983. You agree it is not exactly straight forward though in all cases?

(Mr Dobson) It may not be straight forward and it is certainly the case that some people have been unfairly and unreasonably suspended but it is also the case that quite a lot of people should have been suspended and have not.

984. Yes.

(Mr Dobson) Where the National Health Service has reached the stage where it says: "For good or ill we think that you are for the time being unfit to take part in activities within an NHS hospital", it is a bit difficult to say you have a regulatory system which will still allow them to do their stuff in the private sector.

Dr Brand

985. I am reassured by Lady Hayman's response because at the moment suspensions happen specifically, not for clinical reasons. You have a cardiologist suspended because he was rude to his colleagues, I think he was telling his colleagues that they were useless and I tend to rather agree with him but they suspended him. There is nobody here from the Isle of Wight. It does rely on good information being passed backwards and forwards.

(Mr Dobson) Yes.

986. One of the things that concerns me a great deal is where things have gone wrong and consultants are taken to court. If there is a chance of them not being guilty their medical protection organisations tend to defend them and if then they are found guilty they get reported to the General Medical Council. If they have not got a defensible case they settle out of court and nobody hears about it. I am extremely concerned about that because we are then handing over regulation basically to the insurance companies who will allow people two or three failures before they say "We will not insure you any more and you cannot work". Are you going to tackle that?

(Mr Dobson) Yes, we find the present situation unsatisfactory and I think the huge majority of doctors find it unsatisfactory as well. We do want to change the situation firstly, by all the measures we are taking to improve standards, to reduce the number of

people not up to it and have measures in place in which people are more likely to be spotted not being up to scratch, given the opportunity for retraining and improvement, or if it is necessary to take quicker and more effective action to stop them harming patients. When we are doing that clearly we have got to have a system, as I say, where if the NHS is saying that they cannot go on yet do something in a private hospital at the same time.

(Baroness Hayman) I think we have to make sure that the alert letter system is used in appropriate cases where there is clinical concern and is not used where a suspension has taken place because of a breakdown of relationships between individuals in a particular working situation which is not a danger to patients. We have to make sure that the alert letter system is only used in appropriate circumstances but then it is shared with appropriate people. Also I think one thing we are looking at in the Department at the moment is not continuing the alert letter system only to doctors but extending the principle to nurses, and Professions Supplementary to Medicine, who equally ought to be covered.

987. May I ask whether you will specifically look at this issue of poor practice being dealt with by settlements out of court?

(Baroness Hayman) Yes.

988. I know that in New Zealand and in the States it is a requirement to report that to the regulating authority.

(Baroness Hayman) Yes.

989. I am very concerned that actually indefensible practice does not get reported to anybody.

(Mr Dobson) Right.

Chairman

990. Can I ask a general question on mental health and I know that John Austin wants to ask a couple of points very quickly. One of the things that we have picked out within this inquiry is there are some 2,000 beds in hospitals in the independent sector related to acute psychiatrist illness and substance abuse. The majority purchaser here is the actual NHS. I have developed a practice, Secretary of State, for taking this Committee to the north of England as often as I can, Yorkshire in particular. As part of this inquiry we went to a hospital in York or near York, Stockton Hall, that you will know, which is a private hospital providing mental health services. It struck us all quite strongly that a substantial number of the patients we saw there, who were all under section, were actually originally from the south of England, particularly the London area. We wondered, in discussion at this hospital, whether your Mental Health Strategy that you will be looking at will address (a) the use of the independent sector to the extent that we are seeing it currently and (b) the extent to which patients are moved substantial distances from their own homes to be treated?

(Mr Dobson) It has certainly been the case that the National Health Service ever since it existed has sent some of its patients to reputable places in the private sector for mental health care and it seems to me that is likely to continue. Like all other patients, if they are NHS patients, the NHS will be responsible one way

13 May 1999]

RT HON FRANK DOBSON MP, MR MARTIN STANIFORTH
AND BARONESS HELENE HAYMAN

[Continued]

[Chairman Cont]

or another for seeing that they get proper treatment. It does seem to me if people are being placed in long stay hospitals or long stay units a long way from their homes then it could be argued—I do not know the details, there may be arguments contrary to the one I am now going to put - if they are being placed somewhere a huge distance from their homes, which makes it very difficult for relatives and other people to visit them, that may be in health terms disadvantageous to them and something which needs to be borne in mind. There is always the question, as with some acute services, if something is really very, very good then it may be worth going to even if it is a long way away.

Mr Austin

991. There is also the issue of after care as well. The caring providers who provide the support when those people leave those hospitals and the possibility for liaison, particularly with social services, is very difficult now.

(*Mr Dobson*) Yes, I think that is the case. There may in some cases be good reasons for doing it, people suffering from a particular condition and some hospitals, NHS or otherwise, may have people with a particular talent in that direction, a particular specialisation, I simply do not know. But, as a generality, people are better off treated in or near their homes for a whole variety of reasons.

(*Baroness Hayman*) I think the point is about ensuring that when there is discharge into the community, for example, and community psychiatric nursing is absolutely predominantly an NHS provision, the right relationships are established and transfer of information to ensure the proper after care. I think it is that matter of communication and making sure that it does not fall down through the gap, as indeed in other parallel areas. We can talk about people who have been in prison, all sorts of different areas where patients have been treated away from their home areas.

992. Can I go on. There is a very wide range of services provided in the independent sector in the sphere of mental health. Do you feel it would be beneficial if all those services were brought within the scope of the proposed Regional Commission for Care Standards?

(*Mr Dobson*) Again, there is a question of where, not the geographical but the functional, boundaries should be drawn. Certainly anywhere that is providing that care should either be covered by the Commissions depending on the nature of the care or by the proposed new regulatory body.

(*Mr Staniforth*) I would like to come in. That is one of the issues that we will be consulting widely on, where these functions should most appropriately be regulated.

993. A final one: will you in your consultation give consideration to expanding the scope of the Mental Health Act Commissioners beyond that of being able to detain patients?

(*Mr Dobson*) We have looked at that but my understanding is they are not particularly keen on such an extension themselves. If they are not, they may think that the best thing they can do is to try to

continue the discharge of their existing functions. Any arrangements that we develop clearly need to bear in mind what is being done and if some relatively small adjustment to their functions would fit with them rather than with any other body then maybe that would be the best way to do it.

994. Will that be in the consultation?

(*Mr Staniforth*) Again, I think we hope to have the report of the review of the Mental Health Act during the period in which we will be consulting. So clearly we will want to take account of what that review says in making our final decisions.

Chairman: We were trying to conclude by six but there is one final question about the timescale for consultation and how that might relate to our report.

Mr Walter

995. Secretary of State, one of the frustrations that the Committee has had with your Department was that when we embarked on an inquiry into NICE your Department laid before the House regulations for NICE the night before we met without either providing copies to the Vote Office or to the Clerks of the Committee. When we announced we were having this inquiry, which we trailed for some months before, just on the eve of the inquiry you announced that you were going to introduce regulations on the private sector. You have referred to those on a number of occasions today, but we do not know what that regulation is going to be. I wonder whether you are waiting for us to give our report or whether we should be waiting for you to show us what those regulations are so that we can comment on them.

(*Mr Dobson*) In this age of declining gentility perhaps we are both waiting for one another and therefore this is to be welcomed. We have been having a very thorough look at this and I had hoped that we would be able to produce a draft and get it round the other government departments and then produce it in time for you to see before we gave evidence and we have not got ourselves into that position. One of the reasons is that we keep thinking of odd things that are not covered and then we have got to try and see how they mesh in. I am sure that when we produce the consultation document there will still be other things and other points, particularly about these questions of boundaries, of functions. I would hope that we would be publishing that within a week or two.

Mr Gunnell

996. And the consultation will make proposals regarding the way in which the regulation is to be funded?

(*Mr Dobson*) Yes. It will be quite clear that we would expect the private sector to pay for the cost of regulation.

997. I hope they will also pay for what goes on and gets passed on to the National Health Service.

(*Mr Staniforth*) Could I make a small point in response to Mr Lewis? While the Secretary of State said he is not in favour of the Ombudsman having a role in complaints, I do not think that means there should not be some independent scrutiny of

13 May 1999]RT HON FRANK DOBSON MP, MR MARTIN STANIFORTH
AND BARONESS HELENE HAYMAN[Continued

[Mr Gunnell Cont]

complaints where a complainant is dissatisfied with how his complaint has been dealt with by a hospital, that there should not be somebody else to look at it, but maybe not necessarily the Ombudsman to do that.

Chairman: Thank you, Secretary of State, Minister and Mr Staniforth, we are most grateful for your co-operation. Thank you very much.

APPENDICES TO THE MINUTES OF EVIDENCE

TAKEN BEFORE THE HEALTH COMMITTEE

APPENDIX 1

Memorandum by Rose Irwin (PM IB)

I submit my evidence in three linked capacities: (1) As a casualty of silicone gel breast implants who received inappropriate treatment from a Plastic Surgeon in the private sector and who has sought but found no access to a formal and appropriate complaints procedure. (2) As a campaigner for further investigation into the silicone/disease link, help for casualties and accountability of doctors and medical bodies. (3) As one who has heard accounts from other casualties through our helpline. These accounts include the practice of harmful procedures both within and outside the NHS. They also include a common problem of the lack of accountability of surgeons across both sectors, but particularly within the private sector.

1. EVIDENCE AS A CASUALTY

In June 1992 I received, from a Mr Peter Ashby, Harley Medical Centre, M/C, a treatment which was strongly warned against, I later discovered in the information to patients and surgeons booklet issued by the manufacturers. This was the practice of external capsulotomy, a banging pushing and cracking process used in the past to soften hardened implants. By 1992 the process was well understood to greatly increase the risk of rupture most particularly in the case of elderly implants. The practice had been strongly advised against for several years.¹ I attach the extracts from the booklet on this. ²I asked Mr Ashby whether the process could possibly be harmful. He very convincingly assured me that it could not, though he told me that it could cause initial bruising which it did. Mr Ashby did not have a mercenary motive in the treatment as he included it in the consultation fee. The result of his treatment, however, was disastrous.

I had, before my visit felt an unprecedented sensation of a bubbling movement within and around the breasts. Some time after this I had developed, I thought incidentally, ME symptoms. I asked Mr Ashby whether there were other examples of this, as two years into my own ill health, I had begun to hear rumours of other women having had problems. Mr Ashby completely dismissed this possibility. However his real negligence, I believe, lay in the fact that he performed dangerous treatment and gave me no hint even of the directives against this or of *any* contra indications, this in the light of my having asked him carefully, more than once about it.

Subsequently, the sensation I had previously experienced and which I learned was implant leakage was radically increased in frequency and intensity. I developed intense pain and my previous symptoms were severely exacerbated.

I did not wish to visit Mr Ashby again as I lacked the financial resources. Mr Ashby had not required a doctor's note from my GP and I had difficulty in persuading my GP at that stage that there was a problem. Eventually, after seven months of increasing pain, illness and gel leakage, my GP agreed to give me a note to see a breast surgeon provided I paid for a private consultation. There was some reason for this on the part of the GP, as I had received a breast scan three months before I saw Mr Ashby which had appeared as normal. I saw the breast surgeon, Professor Mansell, for a fee of £80. I then had to pay for the scan he advised. Professor Mansell expressed concern that an external capsulotomy had been performed. For my part I found it difficult to pay for the consultation and x-rays as I had by now been incapacitated for over a prolonged period. I had originally had the operation performed privately in 1976, in mid career when I could financially afford it. Now I began to feel trapped in a situation I might not be able to pay for.

The scan revealed bi-lateral rupture and leakage and explantation was prescribed.

After much distress and pleading I was lucky enough to have the explantation performed under the NHS. I am aware that here is a case where the NHS had to mop up a case of malpractice in the private sector. However, the situation now, some six years later, is that other women are finding great difficulty in obtaining an explantation on the NHS.

In my own case, the long period of leakage into an ill body has had a serious and long-term effect upon my health. The gel had migrated into my body. I have had a lump of silicone gel removed two years after explantation. I attach verification on this progression.

I felt that the ill advised treatment from Mr Ashby warranted a formal discussion. It has been extremely costly to my health and there should be discussion, recording, accountability of this misadventure. I have had no wish for any financial redress and have made this clear.

¹ I had fully acquainted Mr Ashby of the details of my operation including the age of the implants.

² Attachments not printed.

The problems in terms of any effective complaints procedure are as follows:

- (a) *Family Health Authority*—Not appropriate for this kind of query.
- (b) *Community Health Council*—Here I received genuinely kindly understanding from the Community Health Officer. She agreed that my case should be properly reported and accountability discussed. She felt that there was serious lack of accountability from her experience both in the NHS and private sector, but that it was far worse in the private sector. She could, for instance, have attempted to arrange a proper discussion of my case in her presence had this been an NHS situation, but THE COMMUNITY HEALTH COUNCIL HAS NO REMIT TO INTERFERE IN MATTERS PERTAINING TO PRIVATE HEALTH CARE. This is a very serious omission, I feel and one which needs reform.
- (c) *The Medical Ombudsman*—not appropriate to cases such as mine.
- (d) *The Medical Devices Agency*—From 1995, fellow casualties began to communicate. We learned of the MDA, an new agency of the DOH intended to monitor medical devices.

The MDA has no remit to follow through procedures from surgeons. With regard to case of silicone implants, we are at a particular disadvantage with the MDA. The agency had conducted its own review into a possible disease link before its official installation, so that when flesh and blood casualties tried to report their problems, MDA staff were resistant to these reports. In fact some of us are at present pursuing a complaint against the MDA with the Parliamentary Ombudsman. This comprises evasive responses from the MDA and failure to take up reports of ruptured implants for the required Adverse Incidence procedure.

- (e) *The Parliamentary Ombudsman*—We have had some difficulty here. At first our complaint was thrown out at the screening stage. Later I learned that, out of 2055 submissions to the Parliamentary Ombudsman in 1997/8, only 486 passed the screening stage. It took a year of appeals, quoting of precedents in which complaints against bodies already in the public eye but otherwise on a par with ours had been both taken up and upheld. In the end I just persisted in quoting the book and re-numbering the details of our complaint. At last it has been accepted for investigation. Letters on file if required.
- (f) *The General Medical Council*—This body proved to be remote, slow and very limited in its ability to hear and respond to patients. I wrote formally to the GMC in 1995. I felt that the damage and ruination of my health was important enough to warrant some investigation and discussion which would involve Mr Ashby. I had visited Mr Ashby myself to tell him of the outcome of his treatment, but he was unwilling to accept this. After a long delay, I received a letter from the GMC telling me that my letter indicated that Mr Ashby had acted with good intentions and that the GMC could do nothing further. Subsequently, I learned that the GMC had extended its remit. A part of this extension included a larger number of lay members than hitherto. It was difficult to obtain detailed information on this from the GMC although I spoke to several different officials. I re submitted my complaint. This time I sent copies to a couple of lay members whose names I obtained, not from the GMC but from a Community Health Councillor. I have no idea whether these were ever received by the lay members. The result was again negative. I rang and spoke to an official who eventually told me that there was a process for which my complaint could qualify, whereby a letter is written to the surgeon in question to ask if they will give details of the treatment they used. I tried again through the GMC. This time the result was negative again, in part, the letter said, because of the length of time which had by now elapsed! I gave up. Letters on file if required. My point in mentioning these bodies is so that you can see that patients caught up in the bureaucracy of self-regulating official bodies on the one hand, and irresponsible medical practitioners on the other are stuck between the devil and the deep blue sea.

The position with regard to feedback and complaint is quite unacceptable. Yet Secretary of State for Health, Frank Dobson, complains about the way in which patients take recourse to litigation. I would say to Mr Dobson that, although there may be some silly and well publicised cases in this area, for most, the desperation which drives people to litigation is a disgrace. Moreover, the result is often tragic for the patient as the doctors close ranks and have access to high powered litigation out of the range of most patients.

2. EVIDENCE AS A CAMPAIGNER

Some of this will have already been embodied in my personal account. The aspect I would most wish to take up here is that of patient information and the problems on this which, from accounts I hear, appear to spread across both sectors. However, were the general obligations on this from doctors in the area of plastic surgery given more enforcement, patients using the private sector, would, I believe (knowing that they have less access to complaints procedure than those on the NHS) be more wary of the pitfalls of many hit and miss cosmetic operations at present being performed in this sector.

The recent Independent Review Group Report on silicone gel breast implants made recommendations on pre-operative information, as well as on follow-up procedures. It did not say how they were to be overseen, as well it might not, for the recommendations have no means of enforcement. There is no legal back-up, nor any recourse to the Convention for the Protection of Human Rights on this aspect. The UK has not signed the European treaty on this. I STRONGLY URGE THAT THIS SITUATION BE EXAMINED WITH A VIEW TO THE SIGNING OF THIS TREATY ISSUED BY THE COUNCIL OF EUROPE EUROPEAN TREATY SERIES/164,4,IV,1997. This is a necessity if we are to have any hope that there can be any firm intention on informed consent in cosmetic surgery.

3. HELPLINE—OTHER CASUALTIES

I can, as throughout, relate here only with reference to the silicone problems, but I have heard some horrific accounts of operations which were ill-advised and/or have resulted in damage and ill effects. Two examples, on whom I have access to details, involved implantation of patients while the breasts were infected. Unfortunately, these were performed on the NHS. It is difficult to assess just where this foolhardy approach from surgeons begins. Perhaps when working in the NHS surgeons feel that they must keep up with the operations being tried in the private sector. In the case of the two women I refer to, there were instances of “lost” records and hostility from doctors in general to the problem. Fear, anger and loss of finances led to litigation with the help of legal aid but, in the end, doctors closed ranks and the patients were financially and emotionally bereft, as well as severely and chronically ill. One doctor’s written account justified events by saying the operation in like cases is generally practiced. The warnings to surgeons clearly expressed otherwise.

It may be worth mentioning the obvious fact that many surgeons practice in both sectors and that the attitude in the private sector may spill over into their roles in the NHS. My own feeling is that the demand, the hard sell (see adverts for clinics such as “Transform” and others) in magazines and the enormous power of advertising sustained by the financial resources of the private clinics and the manufacturers, has influenced not only surgeons where there is a clear vested interest involved, but the attitude by practitioners to cosmetic surgery in general, in terms of lack of caution in the interest of cosmetic demand.

People ring to ask me questions which should be answered by their doctors. I get .. “Please could you possibly send me some information so that I can show it to my doctor..” “How do I find out if I have ruptures?” “Can I have explantation on the NHS—I am in terrible pain”. The cost of explantation in the private sector has increased in some cases with the demand. It can range from £1,500 to £4,500.

The waiting list, even for an initial appointment with a view to explantation can be up to two years in the NHS.

I am aware that there are plastic surgeons who are performing health enhancing and life-functioning operations which are admirably conducted. I know, also, that the more responsible plastic surgeons are at last speaking out about the “cowboys” who are not qualified plastic surgeons.

Unfortunately, though, my own experience and that of so many women to whom I have spoken or heard about reveals an extremely worrying side of this field of medicine. I have received too many accounts of women who are stuck in a cul-de-sac of despair because of faulty treatment which they cannot afford to have remedied.

May I say that I have tried to alert some casualties to the invitation to submit their evidence to you. I hear, though, that the closing date for submissions is 15 January 1999. This limited time is further curtailed by the interruption of the Christmas break, so that the submissions of individual evidence will, I suspect be far fewer than the situation warrants. I very much welcome the inquiry and thank the Select Committee for its attention to it.

APPENDIX 2

Memorandum by Michael Miller P7 Marketing Solutions (PM 12)

THE UK SELF-PAY ELECTIVE SURGERY MARKET AND CONSUMERISM

1. EXECUTIVE SUMMARY

1.1 There is only a limited amount of consumerist behaviour exhibited in the private health care market. A large majority of private patients make no choices for themselves as regards their consultant, hospital or admission date. Relatively few know in advance how long they can expect to be in hospital and how much the treatment will cost in total.

1.2 The majority of private patients are badly informed and therefore obliged to take almost everything that they are told on trust. Consequently they are very different from consumers in a conventional marketplace in which price service qualities are compared. Under such circumstances of customer ignorance and provider power, it is inevitable that cases of overcharging and unnecessary surgery are liable to occur. It is only surprising that it does not happen more often.

1.3 Private patients currently do not know:

1. The price or relative market-value of their treatments
2. Whether they are getting the right consultants for their specific conditions
3. Whether the best hospital facilities are being offered to them
4. Whether they are being offered the most appropriate procedure based upon medical outcomes data.

1.4 Therefore there is a need for a public, or a sponsored private, information service that would:

1. Give patients, upon enquiry, considerably more information about their illness on a generic basis (eg, what does it mean to receive a new hip?)
2. Inform them fully, if they would like to know, about their treatment options and the probabilities of success on the basis of generic outcomes-data and the surgeon's own success rate
3. Empower them to make rational choices by collating the prices of hospitals—particularly for the most popular medical procedures—on a fixed price basis
4. Advise them on the issues, if any, as regards the trade-offs between cost and quality

1.5 Private Hospital charges vary widely for the same procedures—even within the same provider groups. Therefore, these differences need to be brought out into the open through publication on a format that brings them together for comparison.

1.6 The success rates of surgeons in private practice vary widely as do the frequencies that they perform particular operations each week. The evidence on these issues should be assembled and made publicly accessible.

1.7 Consultants should also be obliged to justify their proposed treatments for patients on the basis of evidence from the latest medical outcomes data. They should be required to do this in writing, and in plain English.

2. MARKET SIZE

2.1 The premium income of the UK private medical insurance market is estimated to have been £1,980 million in 1997³. Furthermore, according to estimates made for a Monopolies and Mergers Commission Report in February 1994⁴, 15 per cent of all private medical patients were UK domiciled but without Private Medical Insurance (PMI). A further 5 per cent were non-UK residents. Extrapolating these and other ratios presented by the MMC in 1994 suggests the following market breakdown of expenditure on private elective healthcare in the UK for 1997:

Table 1

	<i>Income From PMI</i> £ million	<i>Income From</i> <i>UK Self Pay</i> £ million	<i>Income From</i> <i>Foreign Residents</i> £ million	<i>Total</i> £ million
Hospitals:	1,325	250	85	1,660
Independent				1,408
NHS				252
Specialist Fees	655	122	38	815
Total	1,980	372	123	2,475

2.2 The domestic UK market for self-paid elective surgery was therefore worth approximately £372 million in 1997. The Independent Healthcare Association (IHA) reports that more than 100,000 people paid for their private medical treatment in 1997. This implies an average cost of around £3,700 per treatment.

2.3 The Independent Healthcare Association has a further breakdown of the private revenue of independent hospitals⁵, which when updated to 1997 values, suggests the following split:

³ PMI Market Review At May 1998, P7 Marketing Solutions.

⁴ MMC: Private Medical Services.

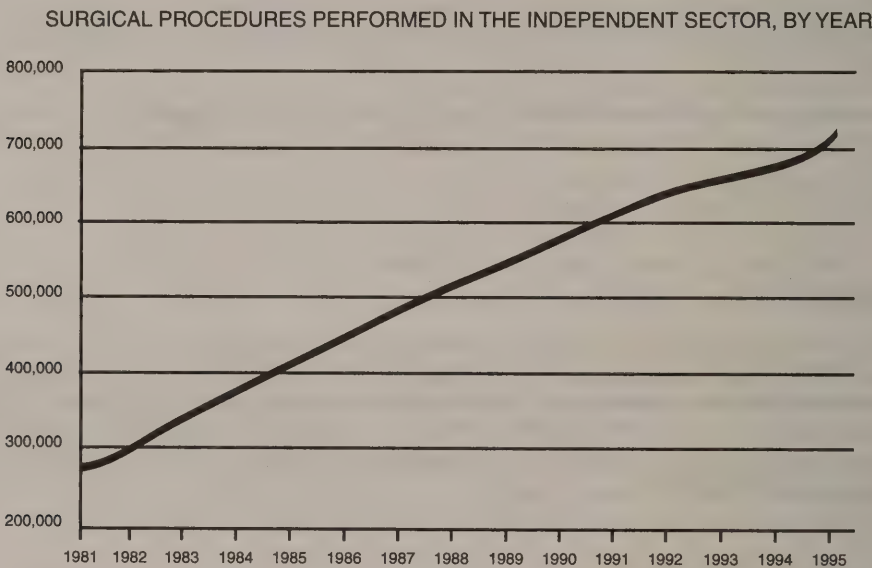
⁵ "Independent Perspectives on Health & Social Care", IHA, 1997, Facts & Figures.

Table 2

	<i>£ million</i>
Acute medical/surgery	1,237
Psychiatric & substance abuse	92
Screening & diagnostics	36
Fertility regulation & abortion	29
Medical/rehabilitation	14
Total Independent Hospital Revenue	1,408

2.4 It is important to appreciate that not all of the income of independent hospitals is from private patients because the NHS now is itself a potential purchaser. On the basis of Laing & Buisson estimates, NHS purchases of acute non-psychiatric healthcare services from independent hospitals in the UK were in the order of £60 million in 1997. However, the NHS's use of independent psychiatric hospitals is also considerable—perhaps accounting for more than half of their patients⁶.

Chart 1



Source: IHA

⁶ The Fitzhugh Directory put the independent psychiatric hospital turnover at £184 million, up 22 per cent in 1995.

3. WHO GOES "SELF-PAY"?

3.1 According to Laing & Buisson, although currently about 15 per cent of private healthcare revenues are derived from self-paying British patients, its share used to be much larger. The 1992–93 survey of independent hospital activity, by Professor Brian Williams (Williams & Nicholl, 1994) of the University of Sheffield Medical School, found that the proportion of England and Wales' resident patients (excluding abortions) who paid for their own treatment in independent medical/surgical hospitals dropped from 28 per cent in 1981 to 21 per cent in 1986 and to 12 per cent in 1992–93:

Table 3

PROPORTION OF SELF-FINANCED TREATMENT EPISODES IN INDEPENDENT HOSPITALS
FOR RESIDENTS OF ENGLAND AND WALES, 1981, 1986 AND 1992–93
(EXCLUDING ABORTIONS):

<i>Age</i>	<i>Sex</i>	<i>1981</i>	<i>1986</i>	<i>1992–93</i>
0-14	male	26.1	12.4	7.7
	female	24.1	13.1	9.7
15-44	male	23.7	16.2	9.4
	female	30.1	24.2	15.3
45-64	male	20.0	14.9	7.7
	female	23.9	18.4	9.5
65-74	male	35.0	24.6	13.7
	female	43.5	32.8	16.3
75 plus	male	38.2	33.3	20.4
	female	58.2	49.1	29.7
All Ages	male	24.9	17.6	10.0
	female	30.8	24.3	14.1
	persons	28	21	12

Source: Williams and Nicholl, 1994

3.2 Although part of the drop to 12 per cent might be attributable to the effects of recession, there seems to have been a long-term downward trend in self-funding of private healthcare since the early 1980s. Information from the major hospital operators and from unpublished IHA market audits indicates a recovery in self-pay demand since then, to a figure now prevailing of around 15 per cent. In the absence of any marked resurgence of demand for PMI, some operators argue that self-pay, allied with long term credit arrangements, will become an increasingly important engine of growth, especially in the over 60s market where private healthcare users have now lost PMI tax relief. However, in the opinion of Laing & Buisson: "it would take a major reversal of purchasing patterns for the long-term trend towards insurance funding of private healthcare to be thrown into reverse".

4. THE OVERSEAS PATIENTS' SELF-PAY MARKET

4.1 The share of revenue generated by non-UK patients has also been declining in recent years, partly as a result of competition from NHS Private Patient Units in London and partly as overseas patients have found alternative sources of treatment in their own countries or other countries in Europe. Overseas patients' contribution to UK independent hospital revenues may now be below 10 per cent. The survey by Professor Williams indicates that less than 3 per cent of non-abortion patients admitted to independent sector hospitals in 1992–93 were resident outside the UK. However, as their treatment is typically more complex their spending per inpatient stay, predominantly in central London hospitals, is about three times higher than average.

5. THE PROPORTION OF SELF-PAY INCOME REVEALED BY TWO SELECTED INDEPENDENT HOSPITAL GROUPS

5.1 The following references to the self-pay market have been made in the reports and accounts of two independent hospital groups.

5.2 *Nuffield Hospitals*

The majority of our patients are covered by medical insurance but in 1997 there has been a strong growth in the number of self paying patients who now account for 20 per cent of our business. We shall continue to seek ways to make our services more easily accessible to those who prefer to make arrangements in this way.

5.3 Community Hospital Group

Insured admission (to June 1997) represented 80.5 per cent of patient throughput; which is a small increase on the position in the year to June 1996 (78 per cent). Self-pay and NHS contract patients account for the balance (19.5 per cent) of total admissions. Whilst the self-pay percentage remained constant, we experienced a significant decline in services to GP fundholders and the NHS.

6. COMMON SELF-PAY MEDICAL PROCEDURES

6.1 *The following are some guideline prices for "Fixed Price Surgery", excluding doctors fees, quoted by the Cromwell Hospital for some of its most common operations*

Table 4

<i>Operation</i>	<i>Hospital Stay</i>	<i>Typical price excluding consultant's fee</i>
Wisdom tooth extraction	As a day patient	£635
Removal of tonsils	One night	£975
Circumcision	As a day patient	£635
Repair of hernia	One night	£1,055
Varicose vein removal	One night	£1,055
Vasectomy	One night	£895
D and C	As a day patient	£495
Hysterectomy	Six nights	£4,000
Cataract	As a day patient	£925
Hip replacement	Twelve nights	£7,770
Arthroscopy	As a day patient	£715
Breast augmentation	One night	£1,415
Face lift	One night	£1,325

6.2 The "breast augmentation" and "face lift" operations itemised above serve as a reminder that "cosmetic surgery" is an important part of private medical market that is self-paying. So too, no doubt, are abortions. Mainly though, the key self-paying market is people aged over 75 (and usually women) having operations such as cataract and varicose vein removals, and joint replacements (see also table 3 above).

7. WHY UNINSURED PATIENTS GO PRIVATE

7.1 A paper for the Institute for Health Policy Studies⁷ (IHPS) researched a population of 650 patients in some independent hospitals situated in the West Country. Nine per cent were uninsured and paying the full cost of their treatment themselves. Although that 9 per cent self-paying proportion is well below the 15 per cent calculated for the MMC report, the figures might be consistent on the basis that a higher proportion of self-payment can be expected in the London and South East area where more people exhibit the factors that characterise this group. According to the IHPS research, these factors were:

- 1. Aged 65 or over: 47 per cent of uninsured private patients were of retirement age.
- 2. Female: 78 per cent of the uninsured private patients surveyed were women.
- 3. In the cases of men, former membership of an occupational PMI scheme (eg that ceased on retirement).
- 4. Suffering from "pre-existing conditions" that precluded PMI membership.

7.2 Although the reasons for "going private" are broadly similar for both the insured and self-paying patients, there are also some important differences in the attitudes and motivations of the two groups. "Avoiding NHS waiting lists" (61 per cent); "better environment" (28 per cent); "choice of admission dates" (25 per cent); and "better care" (21 per cent) are important to all, but "so as to use health insurance" (38 per cent) is obviously only a motivation for those that have it.

8. CONSUMERS AND THEIR LACK OF CHOICE

8.1 The study by Wiles and Higgins for the IHPS serves to confirm anecdotal evidence that there is only a limited amount of consumerist behaviour exhibited in the private health care market. In their study, they found that only 27 per cent of the 649 patients surveyed had made a choice themselves as regards their consultant, the hospital and their admission date. Only 34 per cent knew how long that they would wait before admission, how long they expected to be in hospital and how much the treatment would cost in total.

⁷ "Why Do Patients Go Private?": A Study Of Consumerism In Health Care, by Rose Wiles & Joan Higgins.

8.2 The majority of private patients are therefore badly informed and therefore obliged to take almost everything that they are told on trust. Consequently they are very different from consumers in a conventional marketplace in which prices service qualities are compared. Under such circumstances of customer ignorance and provider power, it is inevitable that cases of overcharging and selling unnecessary surgery is liable to occur.

9. THE PROPOSED SOLUTION—BETTER INFORMED CONSUMERS

9.1 Private patients currently do not know:

1. The price or relative market-value of their treatments
2. Whether they are getting the right consultants for their specific conditions
3. Whether the best hospital facilities are being offered to them
4. Whether they are being offered the most appropriate procedure based upon medical outcomes data.

9.2 Therefore there is a need for a public or private information service that:

1. Gives patients, upon enquiry, considerably more information about their illness on a generic basis (eg what does it mean to need a new hip?)
2. Informs them fully, if they would like to know, about their treatment options and the probabilities of success on the basis of outcomes data and the surgeon's own success rates
3. Empowers them to make rational choices by collating the prices of hospitals—particularly for the most popular medical procedures—on a fixed price basis
4. Advises them on the issues, if any, as regards the trade-offs between cost and quality

9.3 Private Hospital charges vary widely for the same procedures—even within the same provider groups. Therefore, these differences need to be brought out into the open through publication in a format that brings them together for purposes of comparison.

9.4 The success rates of surgeons in private practice vary widely as does the frequency that they perform particular operations each week. The evidence on these issues should be assembled and made publicly accessible. Consultants should also be obliged to justify their proposed treatments for patients on the basis of the evidence of the latest medical outcomes data. They should be required to do this in writing, and in plain English.

January 1999

APPENDIX 3

Memorandum by Dr Sarah Myhill (PM 13)

I am a General Practitioner, but I also run a small private practice. I am also the secretary of a medical society, the British Society for Allergy Environmental and Nutritional Medicine. We produce our own journal namely the Journal of Nutritional and Environmental Medicine.

Most of the so-called complimentary therapies such as aromatherapy, acupuncture, manipulation and so on have a low potential to do harm, are widely available with low profit margins, and increasingly are coming under scrutiny from the Practitioners themselves. My experience is that these techniques are extremely safe and I don't recall having seen a patient who has been significantly harmed or a serious diagnosis delayed by patients consulting such Practitioners.

However the reverse is true when speaking of private medical practice.

The extent of regulation, monitoring and inspection of healthcare outside the NHS should be in direct proportion to two things:

- (1) The degree of damage that it is possible for that Provider to do.
- (2) The financial profits which may be made from such an activity.

My view is that where regulation is needed it is amongst doctors. They have huge potential to do harm, are not easily available to the general public and often charge extortionate fees for services. I have seen problems in the following areas:

- (1) A patient of mine visited a private mammography screening service because she had found a breast lump. She was simply given a mammogram. This showed microcalcification but she was told by the private screening service that she did not have cancer. She was not seen by a surgeon. She went on to develop breast cancer and has since died.
- (2) I have seen three patients who have received liquid silicone injections into their face. Two went on to develop multiple sclerosis one has chronic facial pain. Liquid silicone has never been licensed for use.

- (3) I have seen many women with ill-health problems following silicone breast implants. They have clearly never been properly informed as to the risks associated with implants and their rupture rates. I know a recent Independent Review Group has made recommendations but I am not aware that there have been any resources made available to enforce these.

I think it should be incumbent on all qualified practitioners to

- (a) write to the patients' General Practitioner whenever consulted to let them know what is going on. This would at least provide a safety net whereby advice which is clearly unbalanced is picked up.
- (b) the practitioners themselves should have no vested interest in the treatment being offered. Where treatment is services (for example surgery) the practitioner should quote an hourly rate. In the above examples patients were charged exorbitant fees.

December 1998

APPENDIX 4

Memorandum by Bromley Health Authority (PM 15)

INTRODUCTION

Bromley Health Authority Registration and Inspection Unit currently register and inspect 31 Nursing Homes, six Nursing agencies and three facilities with lasers. There is one Registration Officer and one Nursing Homes Inspector. Within the inquiry's remit of private and other independent healthcare provisions our unit has two private acute hospitals and one private acute psychiatric hospital, St Christopher's Hospice and three provisions with lasers.

SUBMISSION

We welcome this inquiry as we think the Registered Homes Act 1984 and Regulations (S.I.1578) have not provided a suitable tool against which to regulate private and independent healthcare. In particular Regulation 12 is not an adequate tool against which to judge high tech procedures routinely undertaken in independent hospitals. We were encouraged to accept results of quality audits in these provisions HSG(95)41, however many of these audits are undertaken internally and their quality varies according to who undertook the work. We believe that there is a need for regulation of private and independent healthcare. The market alone is not sufficient to guarantee standards of care. The need to make a profit and pursue the development of the businesses can override ethical issues. Regulation can provide an accountability structure. However, regulation must be relevant appropriate, meaningful and have enforcement power.

CLARIFICATION OF PROVISIONS TO BE REGULATED

Currently there is confusion around what provisions should be regulated. We would welcome a framework to clarify exactly what needs regulating eg.

- Acute Hospitals (including ITU)
- Psychiatric hospitals (including ITU)
- Forensic Medicine
- Drug and Alcohol Detox Units
- Termination Clinics
- Fertility Clinics
- Hospices
- GP surgeries with an extended role ie minor ops
- Private Clinics
- Medicenters
- Private wings in Trust Hospitals run by Independent Companies
- Lasers
- Cosmetic lasers
- Sports Clinics

It is obviously important that the regulator has the relevant clinical expertise in each of these areas, however, common to all of them is the knowledge of relevant legislation, statutory duties and their underpinning rational objectivity, independence, consistency, even-handedness.

CLARIFICATION OF FRAMEWORK FOR INSPECTION REPORTS

The framework suggested in HSG 1998/047 is not suitable for use in acute hospitals/settings. It is acknowledged that in HSG(97) that hospices, acute hospitals and clinics will need a tailored document reflecting different types of services and different basis of inspection. No guidance has been received.

CLARIFICATION OF COMPLAINTS PROCEDURE

The public's expectation is that the Health Authority can investigate on its behalf all aspects of a complaint within an independent acute hospital setting. In particular complainants have been dissatisfied by our inability to judge the clinical competence and decision making of the healthcare professionals involved in any complaint. We would welcome clarification of responsibilities and suggest that there should be a process similar to that used in the NHS.

January 1999

APPENDIX 5

Memorandum by the Institute of Chartered Secretaries and Administrators (PM 16)

The Institute of Chartered Secretaries and Administrators is the leading body in governance and administration, qualifying Chartered Secretaries for company secretarial and other senior roles within a wide range of organisations.

The Institute has consulted with a number of its members regarding the regulation of independent health care. The views of members providing nursing home care in both the private and not-for-profit sectors are represented below.

1. EXPERIENCE OF REGULATION

Members commented that the existing regulation is outdated in its scope and applicability. The multiplicity of legislation and regulation governing the inspection of nursing home care creates a monitoring and inspection process that is onerous, taking up a disproportionate amount of management time. The effect of this can be that the provision of healthcare services becomes secondary to meeting the requirements of the regulations.

In spite of extensive regulations and detailed inspections, inspection reports are often bland. Although the reports are usually equitable and factual, they fail to praise good practice or give positive encouragement to staff. In addition, reports do not give sufficient information on the services inspected to enable prospective patients and their carers to make informed choices between different providers.

There are also concerns regarding the consistency of monitoring and inspection, with many authorities adopting their own standards, some beyond the statutory requirements. The quality of the inspection process itself is also variable. Some inspectors have had no previous experience of the independent sector or the healthcare setting in question. Inspectors have also been known to impose personal values and preferences in interpreting the regulations, for example in relation to the method of providing personal care and the decoration of rooms.

This inconsistency in monitoring and inspection extends to the treatment of different providers. The regulation of NHS facilities is more relaxed, although patients will expect a common baseline regardless of the status of the provider. This position is particularly anomalous given that private patient facilities run by the NHS in NHS hospitals are not subject to registration and inspection.

2. COMPLAINTS PROCEDURES

Members consider complaints procedures to be accessible to patients and recognise the value of complaints in instigating service improvements. However the current procedures do not sufficiently allow for informal resolution, as formal investigations are instigated for minor complaints. This is time consuming and expensive and may serve to inflame, rather than resolve a situation.

3. CONCLUSIONS

Current experience indicates that any new provisions for the regulation of healthcare need to be flexible in order to cope with developments in the field. Such flexibility may involve a greater degree of self-regulation, an approach that would complement the development of clinical governance.

Specific suggestions for improvements to the regulatory framework are given below.

- Harmonisation of requirements across statutes, creating consistency and simplifying the current range of regulations.

- A national inspectorate, applying national standards which are applicable to all providers—public, private and not-for-profit. This would create a universal baseline of service, allowing equitable comparisons between providers, facilitating Best Value assessments and patient choice. The national standards should incorporate quality assurance tools such as ISO and those developed by the Kings Fund.
- The introduction of an informal, preliminary stage of the complaints process. This would allow providers to resolve minor complaints informally, with the minimum amount of disruption to staff and patients. More formal investigation by inspectors would then be reserved for serious complaints or complaints that have not been resolved to patients' satisfaction at the informal "in house" stage.

The original question posed by the Health Committee was extremely wide, and somewhat vague. I trust that the comments given do fall within the Committee's terms of reference and that they prove useful to your deliberations.

January 1999

APPENDIX 6

Memorandum by the Chief Executive Officer Charter Europe (PM 17)

SUMMARY

This report outlines the benefits of inspection across all sectors including the independent sector. There should be a balanced approach validating what is good and improving that which is not. If the independent sector doesn't receive a clear message from the government about how they can contribute, this debate will be just another costly exercise which adds to bureaucracy and underestimates the basic laws of supply and demand for services.

As Chief Executive Officer of Charter, I welcome the position taken by IHA in explaining the position of psychiatric hospitals operating in the independent sector and their views about regulation and inspection of private facilities.

Charter welcomes the opportunity to have regulation and inspection. This provides support for good standards and good practice. It encourages a dialogue between the independent and statutory sector. It provides a safety net, ensuring compliance with policy and procedure to make the hospital a safe place for staff and patients.

I do feel strongly that calling psychiatric hospitals in the independent sector "Registered Mental Nursing Homes" is inappropriate and confusing, and I feel that the inspectorate should have some formal psychiatric training. I also feel that the objective should be to extend these inspections to all psychiatric providers, whether they be in the independent or statutory sector as soon as possible. This should identify any abuses or deficiencies and encourage good practice nationally.

Staff from the independent sector should be invited to join inspection teams and in addition to inspection, there should be more widespread dissemination of good practice that is discovered on these visits. Charter are in a unique position of having one whole hospital dedicated to the care of NHS patients and another hospital where we cater for the needs of privately insured patients, we admit patients from the NHS to speciality units within this hospital. The care and attention for patients, whether they have specialist needs, whether they are public or private patients, should all have the same clinical standards and the same safeguards, with the same opportunities to comment on services and be offered choices wherever possible.

I think there are tremendous benefits from working closely with the statutory services. We have learned a great deal about how the larger health care system functions and operates. In return, I believe service agreements and monitoring visits have enabled clinical and management staff to see the quality of care that is provided in the independent sector, which has helped to dispel some of the myths and stereotypes that have built up over the years. We need to be working alongside each other, utilising every opportunity to get maximum efficiency from the scarce resources in the specialist areas of Psychiatry.

All members of IHA have committed to accreditation by an outside body and agree to maintain documented standards to retain membership. It is important for the future of the mental health sector that there is reasonable transparency about our costs and that we have a way in which we can compare these with costs with those in the public domain. Where services are cheaper but meet the quality criteria, services should be purchased.

More than ever, we need a vision to enable us to go on providing a needs led service that offers comprehensive mental health care to our local inhabitants. I believe I have experienced the beginning of this vision, seeing a local trust purchasing specialist care, sending in their medical staff to work alongside ours, and our staff accepting patients assessed by community teams, and patients treated being returned directly to community teams, to complete the seamless services envisaged for the mentally ill. Working with the public sector, we have identified and responded to the needs of our local community. We have also been innovators.

An area that was particularly welcomed was the provision of 24 nursed care beds for the severely mentally ill patients, which gives them an opportunity to live in a residential environment, but have nursing and

medical cover and full day hospital facilities seven days a week. We have piloted residential services linked to intensive day care, which has reduced the cost of eating disorder beds by 50 per cent. We are committed to a model of assessment, structured therapy programmes, short length of stay in the intensive care areas, and movement as rapidly as possible to the least restrictive and most appropriate level of care (outpatient day care or residential care). We have received great praise from the insurance companies for our quality and cost effectiveness.

This year, we anticipate adding community nurse services and I do believe that our assistance is valued in our local community. We have provided services to receive crisis admissions in central London for the last four years. We have offered a telephone helpline service for seven years. We have offered free education on mental health to industry, schools and local communities for 10 years. We have provided training places for Project 2000 nurses. We offer placements to the "Maudsley Hospital" for cognitive therapy experience. We meet with the Royal College through the IHA. I believe the mental health sector, particularly the acute sector, has come much closer to the main body of provision and I hope this model can be validated for the future.

We continue to have much to learn in the independent sector, but we also continue to have much to give. I believe we have developed a model of psychiatry which is sophisticated and progressive, which uses evidence based methods. All patients experience full risk assessment on arrival and have treatment outcomes measured on admission and discharge. We aspire to a standard of excellence because we are passionate about psychiatry and we want to continue contributing both now and in the future to the British system. Our patients report high levels of satisfaction with staffing and services.

There are many areas of health care which are under-regulated. I don't believe that the mental health sector is one of those, but it may be (as a result of being so heavily inspected) that our services have a much closer fit with the NHS than some other specialities.

In terms of structure of the inspectorate, I would welcome a hospital manager, a psychiatric consultant and a senior psychiatric nurse. In terms of minimum standards, I believe there should be evidence that every patient has been assessed and met the criteria for the specific level of care into which they have been admitted. Staff should be properly qualified and feel supported by regular clinical supervision. Patients should have therapy choices and all patients should complete an exit survey, which should be seen by senior management. Every hospital should have an identified Quality Assurance nurse responsible to check practice and documentation. If these basics are attended to and staff and patients are happy, then I would suspect that the treatment model is a good one.

All treatment areas should be scrutinised by an inspectorate, particularly specialist areas in Psychiatry, including Addiction services and Eating Disorder services. Unqualified staff should be supervised by qualified staff and national guidelines should be established for minimum staffing levels.

I believe all mental health professionals, particularly in the independent sector, have shown concern about the growth of counsellors and psychotherapists who operate without medical direction or supervision and where no audit trail is possible, this is dangerous practice. The insurance companies have taken the lead in refusing payment unless therapists are operating responsibly, under supervision, in a hospital environment, and we welcome this.

I believe that in the future, there will be a major growth area in 24 hour nursed beds. This area needs careful consideration. Over-regulation could lead to the psychiatric residential environment being transformed into an institutional one, but careful regulation and inspection should continue with due regard for the patients' safety. Qualified staff and supports should be available, but a more homely environment should be encouraged. Again, this would pose no difficulty if the inspectorate consisted of a psychiatric nurse, a consultant psychiatrist and a lay person or hospital manager. Treatment regimes should be validated if they are being purchased.

There still continues to be different interpretations of acceptable practice. It is very important to have clear national guidelines and national standards to encourage inspectors and the hospitals inspected to form good relationships, but also to be very clear about consequences if standards are not upheld. When standards are interpreted very differently, this causes concern and is difficult to resolve.

Many standards emanate from a consistent staffing plan. In the private sector, there is higher job satisfaction, low turnover and less sickness and absence. This should be investigated and its lesson applied to the public sector. We should share training and development and not be afraid to do things differently in the future.

APPENDIX 7

Memorandum by Mr Anthony Erian (PM 18)

INTRODUCTION

I have been practising Cosmetic Surgery for the past 22 years and I specialise in this field and I have also written several articles on this subject. I am happy to furnish you with any details in my CV upon request. I have recently delivered a lecture to the Royal Society of Medicine for the section of Plastic Surgery on the very subject you are investigating. I have put forward several recommendations, after studying the subject for several years, that could be of value to your Committee.

PRESENT APPOINTMENT

Consultant Aesthetic Surgeon at: Guy's Nuffield House, Guys Hospital, Newcomen Street, London SE1 1YR

Department of Aesthetic Surgery at Guy's Nuffield House, Guy's Hospital Private Wing. Run by The Guy's and St Thomas's Trust. I am involved in a weekly operating list and routine clinics. Total number of cosmetic surgery patients performed per week = 2-6 cases. There is a full time RMO present.

Medical Director and Director of Training for Cosmetic Surgery at: Cambridge Private Hospital, Cambridge Road, New Wimpole, Cambs SG8 5QD

Cambridge Private Hospital is a totally dedicated unit for Aesthetic and Reconstructive Surgery. This unit is fully equipped and approved by the Area Health Authority. I perform two lists per week and two outpatient clinics. The Department has affiliation with Psychotherapy, Beauty Therapy, Dermatology, ENT and Maxillofacial. RMO is present full time at the hospital.

Private Practice: 10 Harley Street, London W1N 1AA

EUROPEAN ACADEMY OF COSMETIC SURGERY

Is one of the largest organisations in Europe, is a registered organisation with head offices in:

- Königsallee 22, 40212 Düsseldorf, Germany
- 43 Cambridge Road, New Wimpole, Cambs SG8 5QD

The Academy currently has 600 members and 300 affiliated members. By-laws can be supplied upon request.

DEFINITION OF COSMETIC SURGERY

Cosmetic comes from the Greek "Kosmetikos" meaning adornment. Therefore by inference cosmetic operations are performed on the "normal" although what constitutes normality is often dictated by subjective assessment. Herein lies the danger in this branch of surgery.

DEMAND

It appears that cosmetic surgery seems to be on the increase both in the UK and in Europe. Basically because survival is no longer the only principle effort—quality of life is also as important.

Cosmetic Surgery is now performed mainly in the Private Sector as the National Health does not cater for it unless there is evidence of psychological or functional disorder.

THE PRESENT SITUATION

Cosmetic Surgery at present is performed by Cosmetic Surgeons, Plastic Surgeons, ENT Surgeons, Ophthalmic Surgeons, General Surgeons, Oral Surgeons, Fascio Maxilla Surgeons etc. The fact that we have divided the patient into parts and think that the patient belongs to us—in fact they belong to the patient. The fact is that there is *no specialist training in cosmetic surgery* and although the GMC have set up a specialist register it does not guarantee that they are capable of performing cosmetic surgery as people accredited on this register are in fact not trained in this discipline and others who are trained and proficient in this field do not appear to be on the register. This could create substandard surgery and be misleading to the public. There is no one group of specialists that should claim the right of performing cosmetic surgery. In general to correct this dilemma my recommendations and the comments of the Board of the European Academy of Cosmetic Surgery should be as follows:

- A. Accept cosmetic surgery as a separate discipline.
- B. To recognise training in cosmetic surgery.
- C. To develop a think tank to monitor accreditation and training in the field of Cosmetic surgery regardless of the original discipline a surgeon was trained in.
- D. Identify and outline the role and limitations of every speciality according to the Training eg, an ENT Surgeon should only perform Facial Surgery ie, Rhinoplasty.

These recommendations will ensure that only people who specialise and train in the field of cosmetic/aesthetic surgery would be allowed to perform such procedures.

Recommendations to Improve Surgeons' Training

- A. Find ways and means to stop involvement of non medical personnel infiltrating cosmetic surgery and preying on the uninformed public. A patient who is seeking Cosmetic Surgery should only be advised by a trained surgeon.
- B. Regulate and standardise the influx of surgeons from abroad to ensure that the Training is standardised and unified cross the board.
- C. Find ways and means to improve communication amongst colleagues. Relationships should be constructive rather than destructive. Inter-collate all the disciplines that tend to practise cosmetic surgery at present.
- D. Set up training programmes based on innovation and research. Training programmes and continuous medical education must be updated regularly. A review body should access and review performance of surgeons. This should be an independent learned committee, capable of fair assessment and evaluation to ensure that the Code of Practise is being adhered to and that the level of performance is satisfactory to protect the public.
- E. A separate Cosmetic Surgery qualification should be awarded to Surgeons who fulfil criteria of the training programme.

Recommendations to Protect the Public

- A. Supply accurate information about any procedure they wish to undertake. This should be certified as accurate by a learned body.
- B. The patient should only consult with the specialist who will undertake the procedure so that counsellors and non trained personnel should not sell cosmetic surgery as this can lead to disastrous effect.
- C. A preoperative counselling session to take place prior to surgery to ensure that patients understand the information given and the surgery they are about to undertake.
- D. GP's ought to be more involved and be more educated about Cosmetic Surgery. Liaison between the surgeon and the GP should be a close one—subject to the patient's consent.
- E. Provision should be made to follow a directive that services must be provided before, during and after surgery to maintain continuity of treatment and increase the level of care.
- F. Surgeons should not undertake any procedures in their offices unless these offices are checked for suitability by the Area Health Authority.
- G. A standard "Consent Form" should be used across the board, with information including complications etc, made available to the patient at least one week in advance of surgery to ensure that they have had enough time to digest the information prior to surgery and to make a fully informed decision.

January 1999

APPENDIX 8

Letter from the Chairman of APROP to the Chairman of the Committee (PM 49B)

First of all, my colleagues and I wish to thank you and your Committee for inviting us to give evidence before you on Thursday last and for your very kind reception. I take this opportunity also to express appreciation for the unstinting help given to us by your officers, particularly Dr Berger and Mr McShane.

Enclosed is a copy of the DoH letter you asked for. It defines clearly the limits placed on the remit of health authority inspectors who are unable to enquire into the clinical care of patients in private acute hospitals.

The background to this letter was the assertion by government ministers that health authorities could impose local conditions when licensing or re-licensing private hospitals. This was denied by the lawyers

advising the health authority I was involved with and they proved to be correct. Private hospitals are licensed as nursing homes and as such they are inspected. This makes the claim still being made that private acute hospitals are regulated adequately and inspected twice a year, at best misleading half-truths.

You also questioned me on the use of NHS intensive care units by private hospitals after I said that Dr Vallance-Owen, Medical Director of BUPA, had stated that BUPA would no longer pay for the use of such facilities.

I phoned Dr Paul Lawler, President of the Intensive Care Society, to establish what the position is. Dr Lawler said that it is complicated. When in office, Dr Boateng said that if a patient in a private hospital is considered an emergency such a patient can be treated at no charge in a public hospital's ICU. That presumably is still Government policy. Recently, Baroness Hayman said that the private sector should pay, presumably a personal opinion.

Some NHS Trusts have negotiated local deals with the private sector. One such is The Royal Berkshire and the other is in Portsmouth. The latter has a fully equipped ambulance, staffed by the intensive care unit, which goes out to emergencies, stabilises the patient and brings the patient back to the ICU. Private hospitals are charged both for the ambulance service and for the ICU bed.

The Intensive Care Society is currently sending out a questionnaire to its fifteen hundred members asking them how many patients they admitted last year from private hospitals. I am sure that the Society will make this information available to your Committee when it is collated. As you know, ICU staff resent having to give up their precious beds to the victims of medical accidents in private hospitals and delay further the serious operations which cannot be undertaken without ICU beds being available.

March 1999

Annex

Copy of a letter from the Head, Operational Policy Unit, NHS Executive to APROP

Thank you for your letter of 5 February to Baroness Jay following up the recent meeting that you and your daughter had with the Minister. I have been asked to respond to the request in your letter for clarification of the powers of Health Authorities to impose local conditions when registering private hospitals.

The registering authority specifies in the Certificate of Registration the maximum number of persons to be cared for at any one time in the facility. Conditions may be specified as to the age, sex and categories of persons received in the facility. The registering authority may specify in a notice the numbers and types of qualified nurses and, additionally in the case of a maternity home, the number of certified midwives, who must be on duty in the facility at such times as may be specified.

So, as you can see, there is some scope for imposing local conditions, but only in relation to numbers and types of patients, and nursing staff.

16 February 1999

APPENDIX 9

Memorandum by Advantage Healthcare (PM 21)

EXECUTIVE SUMMARY

1. This is a submission from a highly experienced healthcare provider who suggests combining purchasing and inspection functions and having a central register of fit persons.
2. He also advocates a greater focus on outcomes, rather than the current more mechanistic attention to inputs.
3. He finally advocates an appeal mechanism to represent providers on the rare occasions when an authority takes advantage of the imbalance of power in their relationship with providers.

THE AUTHOR

4. Peter Gwatkin is Managing Director of Advantage Healthcare Management Limited, a company offering long term care services including care for older people; people with learning disabilities and mental health problems including mentally disordered offenders; adolescents with emotional and behavioural difficulties; and people with brain injury. The company operates over 2,500 beds and is in the largest 10 providers in the UK.

5. Peter Gwatkin has worked as a manager and director in the independent healthcare sector since 1986. He has been a director of publicly quoted company. He has represented the independent sector in a number of different forums, including within the King's Fund.

THE REGISTRATION PROCESS

6. The 1984 Act was clearly drafted without the fore knowledge of how the sector would develop.

7. The separate application and interviewing process required of this company has involved me in 51 interviews between August 1997 and December 1998. 42 interviews took the whole day, taking into account travelling time. Every day interviewing was a day not supporting the homes.

Recommendation 1

There should be a central register of persons and organisations deemed to be fit.

8. Several authorities requested that all the directors and company secretary should attend the interview which, if we had not resisted, would have been very disruptive to the running of the organisation.

Recommendation 2

A single director should be adequate to represent a company.

9. Over half the acquisitions were delayed by the need for each authority to police check the directors.

Recommendation 3

See recommendation 1.

10. The overwhelming majority of interviews and applications were handled professionally and with courtesy but there was a very real feeling of "going through the motions".

11. A small number of authorities were hostile, uncompromising and far from exemplars of the principles of public service.

Recommendation 4

There should be an appeal mechanism to represent providers who are being victimised.

INSPECTION PROCESS

12. The overwhelming majority of inspections are carried out in good faith, professionally and with courtesy. Over the last decade, homes within my responsibility have been inspected by over 70 authorities.

13. But there are structural issues:

a. Comments beyond the competence of inspection officers

- (i) Inspecting officers list recommendations and requirements which are neither within their legal jurisdiction to make, nor always in the manner which a private company might wish to operate their business. For example, recommendations about the management structure of a home.
- (ii) The experience of inspecting officers is nearly always within the NHS or social services departments. These organisations have very different cultural and organisational characteristics to small, customer sensitive and innovative organisations in the private sector. As a consequence, most advice from inspectors is out of context of a small nursing or residential home.
- (iii) This issue in theory becomes more relevant since open reporting, since, in theory, exposing an issue in public is intended to exert pressure on operators to comply.

Recommendation 5

Inspecting officers are reminded of the extent of their powers.

Recommendation 6

There should be an appeal process against over ambitious inspection reports.

b. Focus on inputs not outcomes

- (i) Most inspecting officers agree that their inspections focus on the inputs, for example the number of staff on duty and the variety of the menu, rather than the outcome; the quality of care delivered and the enjoyment of the food on the plate.
- (ii) Every authority prepares guidelines for inspection and registration. Most look like a blueprint for the operation of a service which is exported from the NHS or social services. These are the very models we are trying to adapt to the more personal needs of people living in long term care.

Recommendation 7

Rather than creating thick manuals on how to do things, the new regulatory environment should be about the achievement of specific outcomes. Please leave it to the operator to determine how to do it.

c. The Big Picture

- (i) Most inspection officers focus on the narrow function of inspection and are not really able to see the overall dynamics between purchaser, provider and regulator in a rapidly changing environment.
- (ii) For example, the introduction of the minimum wage will have a profound impact on homes in the North where incomes have historically been lower than in the South. Whilst everyone will be pleased to see lower paid staff achieve an improvement in their living standards, it is beginning to emerge that local authorities are not going to make any compensatory increase in fees. In many residential homes, the total salary costs are likely to increase by some 15–20 per cent whilst fees are to be increased by some 2–3 per cent. Unless homes can reduce staffing, many will cease trading. I know from my own experience that a high proportion of residents who have to move from one home to another survive for only a few days or weeks after the move.
- (iii) A number of authorities are taking a limited view towards the impact of the minimum wage. They are claiming that the staffing levels they specify in their staffing notices are immutable. I would argue that lower staffing levels are preferable to the alternative, an otherwise good home closing down.
- (iv) The problem occurs because purchasing and inspection are separate functions each with a completely different agenda. Inspection wanting higher standards; purchasing wanting lower costs.

Recommendation 8

That purchasing and inspection of services is combined within a single organisation, saving overheads and putting inspection within a “quality assurance” framework, rather than an isolated inspection one.

APPENDIX 10

Joint Memorandum by Sunderland Health Authority and Gateshead and South Tyneside Health Authority (PM 22)

1. INTRODUCTION

1.1 Under the Registered Homes Act 1984 and the associated regulations, Sunderland Health Authority and Gateshead and South Tyneside Health Authority have a statutory obligation to register and inspect all independent healthcare facilities located within their boundaries.

1.2 To ensure that these arrangements are met both Authorities manage the statutory function through a jointly established Registration and Inspection Unit operating at arms length from the commissioning functions of both Authorities. This Unit was established on 1 April 1996 having delegated responsibilities from both Authorities. The span of responsibility covers 73 organisations with a total of 3,182 beds.

1.3 I am the Registration Officer for both Health Authorities and the Head of the Registration and Inspection Unit. My evidence is submitted for Sunderland Health Authority and Gateshead and South Tyneside Health Authority.

1.4 My background includes Director of Nursing Services of a 658-bed acute general hospital for two years and Nurse Advisor/Registration Officer to Gateshead and South Tyneside Health Authority for almost six years which includes Registration Officer for Sunderland Health Authority since 1 April 1996.

1.5 Areas of expertise span regulation of independent acute, sub-acute and long-term healthcare providers including mental health continuing care. Acute general hospital management experience at director level and extensive experience managing critical care services as the lead professional. This included operating theatres, intensive care, endoscopy services, accident and emergency as well as surgical wards.

2. REGULATION

2.1 The existing arrangements for regulating independent health care services have developed in a piecemeal fashion. Responsibilities for regulating those services lie predominantly with health authorities discretion being left with the individual authority in setting standards.

2.2 Currently all independent healthcare establishments registered under the Registered Homes Act 1984, which are not acute healthcare, are lumped as nursing home provision. This is further emphasised by the out dated categories used to register establishments under Part II of the Act. No consideration as yet has been given to sub-acute health care facilities which may or may not be a home for life or provide for the care of the elderly. The sub-acute healthcare facilities indicated include hospices, detoxification units, sub-acute convalescence, continuing healthcare, winter pressures' beds, rehabilitation both physical and mental health, acute mental health and brain injuries to name but a few.

2.3 It is imperative that in considering independent healthcare services they are considered in the context of how the sector is developing and responding to the needs of service planners. No longer are nursing homes' providing services just for the elderly, the independent sector has been and continues to respond in an ad hoc way to NHS policy and service changes. It therefore needs to be considered as part of the healthcare sector as a whole.

2.4 At present there are no obvious links nationally or in policy between the regulatory process and evidence-based standards, guidelines, protocols or the national clinical effectiveness agenda.

2.5 The Government's plans as set out in *Modernising Social Services*, Chapter 4—Improving Standards provides an ideal opportunity to improve the regulatory process across all independent healthcare provision not just those that provide for the elderly.

2.6 There are clear advantages to managing all independent healthcare regulation by the Commissions for Care Standards as they will be independent statutory bodies with their own lines of accountability which should facilitate the following.

- i. The regulatory process will be statutorily and physically independent from the commissioning process across all agencies involved.
- ii. There will be no conflict of interest for inspectors working in an organisation regulating and commissioning from the same provider.
- iii. The three levels of approach to standards development could provide for a consistent approach across large and small service providers covering acute, sub-acute and long term healthcare provision.
- iv. A national lead could be taken in setting key standards around fitness of person and fitness of building. Links could also be formed between the independent sector and the implementation of national service frameworks. A lead could also be taken in identifying minimum qualifications and experience for medical staff and professions allied to medicine who are employed to work in acute and sub-acute provider organisations.
- v. A consistent approach to inspection and reporting could be taken which should include the development of evidence based clinical standards, which could be used in the inspection of independent healthcare establishments.

2.7 To ensure that a rigorous and systematic approach is taken to managing regulation in line with the above the Government needs to ensure the following issues are tackled.

- i. The regulation of private acute care should not be tackled in isolation to all other independent healthcare provision as the range of patients being treated and cared for in the independent sector is diverse and wide ranging with no clear demarkation lines.
- ii. There needs to be clear links nationally and in policy between the regulatory process and the NHS Clinical Governance Agenda.
- iii. The arrangements for funding need to ensure the appropriate skill mix of staff needed to undertake and manage the regulatory process as well as value for money. It is essential that in regulating all

types of independent healthcare establishments the appropriate specialist advisors work in support of the permanent inspectors.

- iv. Nursing agencies at present licenced by local authorities (appendix 1) and inspected on their behalf by health authorities (appendix 2) need to be regulated under the same statutory framework as all other independent healthcare providers.

3. INSPECTION

3.1 *A Consistent Approach*

3.1.1 Health authorities have received relatively little direction from central government as to how inspection should be undertaken. Guidelines issued by the Department of Health in January 1998, HSC 1988/047 (appendix 3) suggest a number of changes to bring health authority inspection in line with local authority inspection.

3.1.2 The most significant change was that health authorities were to make their inspection reports publicly available from 1 April 1998. Open reporting as described has been in place across Gateshead, South Tyneside and Sunderland Districts since 1 April 1997.

3.1.3 The above guidance also required health authorities to use a standard template for publishing the open reports.

3.2 *Significant Differences*

3.2.1 A systematic approach to inspection and the elimination of inconsistencies should be followed wherever possible, however, this is not always possible when client groups differ in terms of ages and needs.

3.2.2 What has been overlooked in HSC 1998/047, and in the White Paper *Modernising Social Services* is that many premises that are registered as nursing homes are significantly different from residential homes. Many of these establishments as highlighted previously provide acute and sub-acute care. The therapeutic philosophy and imperatives that drive such establishments make it impossible for them to fit the "social services" model of inspection.

3.2.3 The use of "lay inspectors" in such areas may be of limited value whereas the employment of specialist advisors, in such areas as laser use or operating theatres, is essential. Even in subacute facilities, specialist advisors for pharmacy, estates, infection control, palliative care etc, are a necessary part of the inspection process. The resource implications of this on health authorities should not be underestimated. Such expertise does not come cheap.

3.3 *Inspection Documentation*

3.3.1 The Department of Health template as set out in HSC 1998/047, for open reporting, lists all of the basic information which reports should contain to ensure a more consistent approach. The audit tool developed by the Gateshead, South Tyneside and Sunderland Registration and Inspection Unit (appendix 4) contains all of the information required in the guidance document but is set out using a standardised methodology for use in all establishments.

3.3.2 Until 1994 the inspection team of Gateshead and South Tyneside Health Authority carried out inspections without the benefit of any form of standardised documentation. Although the team members were experienced, and knew what they were looking for, there were no standards for inspection set down. As a starting point the inspectors turned to the guidelines produced by the National Association of Health Authority's (N.A.H.A. 1985). These had been used as a basis for Gateshead Health Authorities Guidelines for Registration (Appendix 5). Also, Department of Health Guidelines were taken into account as were U.K.C.C. guidance documents.

3.3.3 The construction of the standards in the audit tool is based on the Donabedian model (Donabedian 1970): this identifies the structure and process necessary to produce the outcomes which will meet the stated standard. This model is also the basis of the Royal College of Nurses, Dynamic Standard Setting System (R.C.N. 1990).

3.3.4 Before the Health Authority adopted these standards, an extensive consultation process took place. This took in specialist advisors in estates and buildings, hotel services and catering, infection control and pharmacy. Service providers were consulted, as well as the local authority inspection units co-terminus with the Health Authority boundaries.

3.4 *Audit in Inspection*

3.4.1 The audit tool consists of standards which may be marked in the relevant column as, Achieved (A), Partially Achieved (P/A), Not Achieved (N/A). Where the standard is not applicable to the home in question, this is clearly stated. Additional comments may be added to provide evidence on which these judgements are based. Before the final report is produced, a draft is sent to the home owner for comment. This allows any factual errors to be corrected, and enables qualifying comments to be made.

3.4.2 The final inspection report which is publicly available consists of the completed audit document, which includes a brief description of the establishment and surroundings; together with a pre inspection questionnaire (appendix 6) listing the establishment's facilities; and finally the comments of the registered owner of the establishment.

3.4.3 The inspection reports identify clearly and succinctly what is good about a home and what needs improvement. The reports are qualified in terms of published standards and accepted good practice. The criteria against which such judgements are made are clearly stated. Clear distinctions are made in each report between requirements which are mandatory, and recommendations which are advisory, and for guidance of proprietors and their staff.

3.4.4 The inspection process (appendix 7) and the production of the reports is monitored using a control sheet for each report (appendix 8) to ensure timely undertaking of the inspection which includes timely production and distribution of the report.

3.5 *Experience of Use*

3.5.1 The documents described and attached as appendices have been in use for three years and have proved trouble free. They appear to be popular with home owners and managers who know what standards are expected of them. Clients and relatives have also commented positively on being able to make an informed choice of residence based on clear criteria.

3.5.2 Specific standards for undertaking inspections make the training and induction of new inspection staff easier. Criticism that the document looks reductionist, in that it seems to reduce the inspection process to a "tick box" exercise, does not take into account the fact that inspection still has to be carried out with sufficient thoroughness to allow the boxes to be ticked. *Homes Are For Living In*, Department of Health 1989, uses similar standards statements, these are presented in a grid like matrix and it is suggested that this is used as a basis for inspection for social services inspectors.

3.5.3 This form of documentation ensures that all relevant areas are inspected which reduces the possibility of areas being overlooked and removes the likelihood of subjective judgement by individual inspectors.

3.5.4 Perhaps the final word on the usefulness of the document should be that the Registration and Inspection Unit has been approached by both a major service provider and a number of other health authority registration and inspection units to use the documentation. The service provider requested permission to use the audit tool as a basis for their own internal audit documentation. Other health authorities have asked if they could use the documentation as a basis for developing their own standards for inspection.

3.6 *Future Development*

3.6.1 It is intended that the document attached will be modified and improved on a regular basis in line with policy and practice changes. A major regional clinical audit study is being undertaken by this Unit into accident prevention in nursing homes. New standards are being produced in light of the pilot study findings.

3.6.2 It is already planned that care practice standards will be further developed in the following areas, management of continence, tissue viability, clinical dependency levels, palliative care.

3.6.3 It is hoped that the considerable work that has gone into developing such a robust system will not be disregarded in the drive to change the regulatory system and produce a set of national standards, based only on the residential home model. The indications from studying the White Paper, *Modernising Social Services* are that there is a risk and this will be the case. It needs also to be recognised that health authorities and their registration and inspection staff have much to contribute to improving the regulatory process as a whole.

4. COMPLAINTS

4.1 *Introduction*

4.1.1 Under the current legislation compliance with the requirements of the Registered Homes Act 1984 or its associated regulations requires registering authorities to investigate complaints against independent healthcare providers to ensure that there is no breach of the Act. This requirement covers all independently registered healthcare providers.

4.1.2 If regulation of the above both, acute, sub acute and long-term is to move to the Commissions for Care Standards then the investigation of complaints about those provider organisations also needs to move under the same legislation, whether that is the current legislation or any future legislation.

4.1.3 It should be stressed that at present any complaints made against independent healthcare providers registered with health authorities can only be investigated in terms of that authority's statutory responsibility under the Registered Homes Act 1984. The Government needs to examine the appropriateness or not of this minimum requirement.

4.1.4 No matter which organisation is responsible, it is essential when managing the process of investigating complaints that systems are in place to ensure that the method of investigation is appropriate, thorough and robust. The outcome of the investigation also needs to be effectively communicated to those involved and any lessons learnt from the investigation need to be fed back to those involved to ensure improvement of the service.

4.1.5 Documentation is an essential element of any system and complaints investigation is no different. The statutory agency accountable for the management of the complaints process needs to ensure thorough and systematic recording of both the complaint, the investigation and the outcome of the investigation and the outcome of the investigation so that the process will stand up to future scrutiny.

4.1.6 The purpose of the complaints procedure in place in Sunderland, Gateshead and South Tyneside Health Authorities is not to apportion blame amongst any staff involved in a complaint. It is to investigate complaints to the satisfaction of complainants (whilst being scrupulously fair to staff) and to learn any lessons for improvement in service delivery.

4.2 Background

4.2.1 "Being Heard" the report of the Review Committee on NHS complaints procedure, chaired by Professor Alan Wilson, Vice Chancellor of Leeds University, was published in May 1994.

4.2.2 The Government's revised policy and proposals for the NHS complaints procedure, "Acting on Complaints" was published in March 1995 under cover of EL(95)37 which promised further guidance.

4.2.3 Interim Guidance was subsequently published on 31 October 1995, under cover of EL(95)121. Final Guidance was published in March 1996.

4.2.4 The new NHS complaints procedures based on the final guidance were implemented on 1 April 1996, which coincided with the creation of health authorities taking over the roles of district health authorities and family health service authorities. The NHS Executive issued guidance under cover of EL(96)19(Appendix 9).

4.3 Scope

4.3.1 At present it is the responsibility of the Registering Authority to ensure that no breaches of the registration requirements have occurred. If complaints relate to such matters as possible ill treatment of patients or misappropriation of patients' monies, the appropriate statutory agencies must be involved.

4.3.2 The method of investigation is determined by the type and severity of the complaint, concern or incident in question.

4.3.3 All concerns, complaints, untoward incidents which are brought to the attention of Sunderland, Gateshead and South Tyneside Inspection Unit are investigated. Each is recorded in a complaints/incidents register and a control sheet (appendix 10) is completed and passed on to the lead inspector for the home. The complaint is then investigated in one of the following ways.

- i. An investigation is undertaken by the home, the method used and the outcome of the investigation is then scrutinised by the Lead Inspector.
- ii. The complaint is investigated and reported on by the Lead Inspector.
- iii. The Investigation is undertaken by a multi agency team each officer reporting the outcome to their own agency.

4.3.4 If a complaint involves the registered person of the establishment and it is upheld, it may lead the Registering Authority to decide that the registered person is not a fit person and consideration would need to be given to cancelling the Registration.

4.3.5 Where a complaint relates to the professional conduct of Nurses and Midwives working in registered premises, registering authorities need to consider referring the matter to the United Kingdom Central Council.

4.3.6 It is not the responsibility of Registration and Inspection Units to investigate complaints relating to medical treatment. A grievance brought against a medical or dental practitioner either acute or primary care is directed to the appropriate health authority for investigation.

4.3.7 The above describes the system in place in the two Authorities mentioned, a system which is thorough, consistent and robust and will stand up to scrutiny and the test of time.

5. TRAINING

5.1 Inspection has increasingly become an area of specialised practice which requires specific training in basic and technical skills as well as a thorough knowledge of the background of the legislation and procedures for implementation.

5.2 *Modernising Social Services*—Chapter 4, Paras 4.17 and 4.18 indicate that cognisance will be taken of the need for inspectors to be both trained and competent in both the speciality and the regulation process.

5.3 Regulation of independent health care establishments involves a wide range of client groups. Inspection cuts through traditional career pathways for both full time inspectors and specialist advisors. The breadth and depth of knowledge and skills required to achieve competency in registration procedures, inspection and investigation of complaints is developed at levels beginning with newly appointed Inspectors and progressing to advanced level management of Registration and Inspection Units. Training must be available to meet the profile of the specific inspector and needs to be flexible to allow participants to meet both their individual needs and that of the service.

5.4 Whilst it is a valid argument that the range of inspectors should include those on secondment or temporary appointments, it needs to be emphasised that inspectors need to be trained to inspect and that this does not happen overnight.

5.5 The training must ensure that the inspectors can meet the basic requirements of the role in that they must be able to demonstrate competency in:

- i. Understanding, interpreting, applying and enforcing the relevant legislation regarding the registration and inspection of services;
- ii. Comprehension of the process of inspection and assessment of quality;
- iii. Development of inspection skills necessary to evaluate establishment's ability to conform to the legislative requirements and to encourage good practice;
- iv. Evaluation, documentation and presentation of inspection findings in a manner which will support recommendations;
- v. Using reference and resource materials to support inspection;
- vi. Collection of primary evidence using the competencies gained through Police and Criminal Evidence Act training.

5.6 The inspector must also be supported in attaining generic skills including, assertiveness, contributing as a member of the team, effective communication, report writing and team building.

5.7 With the above in mind whether employed by Health Authority's or Commissions for Care Standards, inspectors need to be adequately trained. They also need to be employed in a post for sufficiently long to ensure their regulatory practice demonstrates a standard of competence that could be tested in law.

6. CONCLUSION

6.1 Regulation in all its forms needs to be thorough, robust, systematic, consistent and well documented. The documentation must stand the test of the judicial process. The Government must ensure that whoever manages the regulatory process implements the principles of good practice in managing registration and inspection.

6.2 The need to regulate all independent healthcare providers by the same statutory agency is self evident. If some are regulated by health authorities and others by Commissions for Care Standards where will the trained regulators/inspectors come from. Duplication of process and people does not provide a consistent and value for money service.

January 1999

APPENDIX 11

Memorandum by Doctor Patient Partnership (PM 28)

It has come to our attention that you have been seeking views on independent health care organisations. The Doctor Patient Partnership is an independent body funded by Government and Health Authorities. Our remit is facilitate communication between patients and health service workers to improve quality of care and the efficiency of the NHS. Our Board of Directors consists of representatives of the Association of Community Health Councils for England and Wales, National Association of Patient Participation, Patients' Association, Health Education Authority, NHS Confederation, Royal College of Nursing, Department of Health, Proprietary Association of Great Britain, Royal College of General Practitioners, The Men's Health Forum and the British Medical Association.

I have met with representatives of several individual IHOs. Most work to a professional code of conduct with the appropriate public safeguards. However some leave the public seriously exposed to risk. They are unaware of the statutory regulations governing the provision of medical services.

For example, one company employs French doctors to provide general medical services at weekends. These doctors do not possess a certificate of equivalent experience from the Joint Committee on Postgraduate Education for General Practice. Indeed the response to my question was that they were "approved by the BMA". This organisation is of course a professional organisation and not a statutory body. The public must have confidence that the doctors they consult are appropriately qualified.

We have particular concerns that IHOs should be governed by the same regulations as NHS bodies and doctors. These fall into six categories.

1. Doctors must be registered with the General Medical Council.
2. Doctors must hold the relevant certificate of prescribed experience.
3. There must be a recognised complaints procedure which is transparent, progressive and with an appeals procedure to an independent authority.
4. There must be guaranteed communication with the patient's general medical practitioner.
5. The patient must be aware of the cost consequences of receiving care in the private sector with respect to prescriptions, special investigations and referral to a specialist.
6. Organisations should work to the same standards and the same philosophy as the NHS.

In addition, we believe all doctors should have personal medical indemnity cover. Currently this is not a requirement for any doctor, though it is promulgated by the General Medical Council in "The Duties of a Doctor". Any public redress assumes that IHO doctors are registered with the GMC.

The current situation in some IHOs leaves patients at risk from being treated by a doctor who may not be qualified to practice in the UK. If a medical accident occurs the patient then only can go to the courts for redress. Furthermore, the IHOs do not have a systematic system of passing on medical information to the patients own NHS GP. We believe this is essential as the continuity of care is the bedrock of safe medicine.

January 1998

APPENDIX 12

Memorandum submitted by PPP Healthcare (PM 29)**EXECUTIVE SUMMARY**

In view of the close practical integration between private and public healthcare services, PPP healthcare believes that it would be beneficial to patients for the two sectors to be governed by equivalent statutory regulatory mechanisms. [paragraph 4.4]

The regulatory environment should be framed to ensure minimum standards across the private healthcare sector for the protection of the public. [paragraph 5.2]

The registration requirement placed upon private hospitals should be separated from the existing statutory requirements aimed at nursing home facilities contained in the Registered Homes Act 1984. [paragraph 7.1.4]

PPP healthcare would like to see new legislation to establish a core set of standards and requirements for private hospitals, which would be applied consistently in all inspections across the country. [paragraph 7.1.5]

The OFT should re-examine the use of price guidelines by insurance companies as such guidance serves to limit open price competition among specialists. [paragraph 7.3.1]

PPP healthcare recommends that wherever possible patients should be given full information before their treatment commences, about the professional fees that will be incurred. [paragraph 7.3.4]

Private medical services should conform to the clinical guidance issued by the National Institute for Clinical Excellence and, further, due consideration should be given to coverage by the Commission for Health Improvement. [paragraph 7.4.3(i)]

Chief executives and directors of private hospitals should have a duty to implement clinical governance policies in line with those proposed for NHS trusts. [paragraph 7.4.3(ii)]

Regulation should require formal, local complaints procedures. [paragraph 7.4.3(iii)]

A new national complaints procedure—perhaps in the form of an Independent Health Ombudsman—for the private and independent sectors, should be established. [paragraph 7.4.3(iv)]

1. INTRODUCTION

PPP healthcare believes it is well placed to comment on the current operation of private healthcare in the UK. We are keen to ensure that all patients receive the best possible care. We hope that the select committee will give careful consideration to our recommendations, which are intended to serve as a constructive contribution to the debate.

2. PPP HEALTHCARE

PPP healthcare dates from 1940 when it was known as the London Association for Hospital Services. In its infancy, the company was actively supported by the medical royal colleges, the British Medical Association and the King's Fund. Today PPP healthcare forms the healthcare arm of the Sun Life and Provincial Holding PLC and serves over 2.6 million people. PPP healthcare's business activities include:

- Medical insurance for individuals and companies in the UK and abroad.
- Occupational health services (Medical and Industrial Services).
- Expert health information services (Access 24 UK).
- Dental care services (Denplan).
- Long-term care insurance (PPP lifetime care).
- Hospital services (PPP/Columbia healthcare owns and operates the Harley Street Clinic, the Portland Hospital for Women and Children, the Princess Grace Hospital and the Wellington Hospital).

3. PRIVATE HEALTHCARE INDUSTRY

3.1 The private healthcare industry includes pharmaceutical and medical appliance companies, hospitals (including NHS private facilities and independent hospitals), retailers and healthcare financial services companies such as PPP healthcare.

3.2 People from all social groups buy health related financial products such as medical insurance, health cash plans and other health products and more than a third of the adult population now owns a healthcare finance product compared with only a quarter in 1995. Over twelve million people are covered by insurers, friendly societies and cash plan providers. Medical insurance covers almost seven million people—approaching 12 per cent of the population by the end of 1997.

3.3 Increasingly, businesses are using the healthcare industry's services—from employee healthcare schemes, such as stress counselling, to medical insurance—to safeguard the well-being of their employees and reduce the numbers of days lost through illness.

4. PRIVATE PRACTICE

4.1 The private sector no longer focuses on minor conditions and procedures. A substantial amount of highly complex care is carried out in the private sector and, in the interests of the millions of people who use these services, private practice should be regulated to ensure that it meets the highest standards of safety and competence. For example, coronary artery bypass graft, angioplasty (widening of coronary arteries), hip replacement and knee replacement are four of the 10 procedures for which PPP healthcare paid the most benefit in 1997. Treatments for cancer now account for 15 per cent of our claims costs. This is in contrast to the types of treatment which predominated ten years ago: varicose veins, wisdom teeth removal, hernia repairs and hysterectomies.

4.2 When framing policy, government often seems to view the private sector in isolation from the NHS. This is inappropriate since the great majority of specialists who work in private sector undertake both NHS and private work. Indeed, even GPs actually work for the NHS primarily on a capitation fee basis and not through salaried appointments. Private practice among GPs is also on the increase. Furthermore, the great majority of patients treated in private practice also receive some elements of care in the NHS.

4.3 NHS purchasing bodies also contract some health services from the private sector, for example, pathology services, and NHS trusts provide healthcare services to the private sector through their private facilities (NHS pay beds now account for about 20 per cent of the private acute care hospital beds in the UK).

4.4 In view of the close practical integration between private and public healthcare services, PPP healthcare believes that it would be beneficial to patients for the two sectors to be governed by equivalent statutory regulatory mechanisms.

5. REGULATION

5.1 The purpose of regulation should be to ensure that the public is provided with a service:

- that is given by professional clinicians who are appropriately trained and registered to provide the care they are offering;
- that is provided by hospitals or other organisations which meet all statutory safety standards and which have operational systems in place to ensure that clinical care is offered in accordance with professional standards and guidance; and
- for which there is an opportunity to seek explanation and redress for any failures in the provision of their care by hospitals and/or specialists.

5.2 The regulatory environment should be framed to ensure minimum standards across the private healthcare sector for the protection of the public. This function should be distinguished from that of purchasing organisations such as PPP healthcare, which seek to ensure that consumers receive the highest possible quality service from healthcare providers.

6. PPP HEALTHCARE'S STRATEGY FOR ACHIEVING QUALITY

PPP healthcare's preferred provider network strategy involves us in establishing comprehensive contracts with selected hospitals across the country. The establishment of our preferred provider network is designed to address three key issues:

- the lack of monitoring of the quality of care delivered;
- the increasing complexity of work undertaken in the private sector; and
- the over-provision of private facilities.

The PPP healthcare preferred provider approval process includes detailed assessment of the quality of service and care at a hospital, including arrangements for clinical governance and regular monitoring and review of the standards achieved. (See Appendix 1 for a summary of the PPP healthcare criteria for assessing the quality of private hospitals, including NHS facilities).¹

7. STRENGTHENING THE REGULATORY REGIME

We wish to highlight the following areas as central to improving regulation of the private sector:

7.1 *Registration of private hospitals*

7.1.1 The only existing statutory inspection requirement is that all private hospitals must be registered with their local health authority under the terms of the Registered Homes Act 1984. The Act primarily covers the registration and inspection of care homes and nursing homes.

7.1.2 We understand that this legislation will be comprehensively revised when the plans contained in *Modernising Social Services* (Cm 4169), the social services white paper issued at the end of 1998, are implemented. The White Paper proposes the creation of eight regional Commissions for Care Standards for England. It is unclear from the white paper how, if at all, private hospitals will continue to be subject to registration when the new commissions take effect.

7.1.3 The current system lends itself to inconsistent standards and methods. In some areas private hospitals are inappropriately viewed as a subset of nursing homes.

7.1.4 PPP healthcare recommends that the registration requirement placed upon private hospitals should be separated from the existing statutory requirements aimed at nursing home facilities contained in the 1984 Act. The reforms to the registration and inspection regime for nursing and care homes presents an opportunity to review the extent and adequacy of the current inspection for private hospital facilities.

7.1.5 PPP healthcare would like to see new legislation to establish a core set of standards and requirements for private hospitals, which would be applied consistently in all inspections across the country.

¹ Not printed.

7.2 *Information sharing*

PPP healthcare agrees with the recommendation contained in Sir Donald Acheson's recent report, *Independent Inquiry into Inequalities in Health* (The Stationery Office 1998), that those providing private healthcare "should be required to give the same routine information on activity and quality of services as in the NHS." This would include inter alia:

- notification of cancer cases and treatments to the appropriate cancer registry; and
- contribution to national audit programmes such as the National Confidential Enquiry into Perioperative Death.

7.3 *Regulation of specialist' charging practices*

7.3.1 The Office of Fair Trading should re-examine the use of price guidelines by insurance companies as such guidance serves to limit open price competition among specialists.

7.3.2 PPP healthcare believes that, in the majority of instances, specialists' charges reasonably reflect the work and expertise that is required in providing their clinical services. Nevertheless, there are some aspects of the way in which specialists make their charges which may be construed as anti-competitive, which fail to provide patients with the information they need to act as genuine consumers and which fail to comply with the spirit of the Supply of Goods and Services Act 1982.

7.3.3 In the majority of cases, patients are not given prior knowledge of the charges to be made for professional services and do not have the opportunity to discuss these or to seek an alternative provider of the services. At PPP healthcare, we have observed a disturbing new trend in which specialist charge incrementally for elements of care which are an integral part of the clinical service. These elements should be included in the charge for that service—for example, extra charges by anaesthetists for an anaesthetic assessment or for local nerve blocks to provide postoperative pain relief, and extra charges by surgeons for each postoperative review appointment.

7.3.4 PPP healthcare recommends that wherever possible patients should be given full information before their treatment commences, about the professional fees that will be incurred. This should be provided in a simple format which ensures that all costs for a particular treatment or course of treatment are included. The information should be readily available when the patient is deciding with their general practitioner which specialist they wish to see.

7.3.5 Professional fees may also be charged separately by specialists in disciplines such as anaesthesia and radiology in which the patient has no advance knowledge of or choice in the specialist providing the service. In such circumstances, information about these fees should be made available with information about charges for the hospital service. The responsibility for this should be with the hospital or unit at which the investigation or procedure will be carried out.

7.4 *Accountability of specialists*

7.4.1 The regulation of specialists is complicated by the fact that they contract directly with their patients. This means that each individual specialist is accountable for their own private practice.

7.4.2 Specialists take admitting rights at private hospitals to provide appropriate support services and equipment to enable them to treat their patients. However, clinical services which require no facilities other than those provided by the specialist themselves (such as out-patient consultations and minor procedures in an out-patient setting) are provided independently by the specialist.

In general, neither specialists nor hospital managers see the hospital as being responsible for specialists' clinical practice. Hospital managers will become involved in rare circumstances in which it is felt that the hospital itself is being brought into disrepute but are reluctant to do so otherwise. Because of this, patients who wish to complain about or question the care they have received from a particular specialist have no recourse to an independent third party or organisational hierarchy to pursue their complaint.

Most private hospitals have a medical advisory committee which controls or advises the hospital manager on the granting of admitting rights. In many private hospitals these committees also take responsibility for ensuring that systems of clinical audit are in place and that the practice of specialists in the hospital conforms with relevant professional standards such as those set by the medical royal colleges and other professional bodies.

7.4.3 PPP healthcare believes that it is essential that specialists practice in a way which conforms to the highest professional standards and that all specialists work only within their current sphere of experience and expertise.

Although PPP healthcare's existing purchasing policies are designed to ensure these objectives are met, there is an urgent need to ensure that a strong regulatory framework is established to ensure these principles are applied in private practice. To address these issues, PPP healthcare recommends that:

- (i) private medical services should conform to the clinical guidance issued by the National Institute for Clinical Excellence and, further, due consideration should be given to coverage by the Commission for Health Improvement;
- (ii) chief executives and directors of private hospitals should have a duty to implement clinical governance policies in line with those proposed for NHS trusts. This should incorporate the requirements for implementation of systems of clinical governance;
- (iii) regulation should require formal, local complaints procedures. There should be minimum requirements for the local complaints mechanisms. These procedures should be mandated to deal with all complaints, including those regarding individual specialists' clinical practice;
- (iv) a new national complaints procedure—perhaps in the form of an Independent Health Ombudsman—for the private and independent sectors, should be established.

January 1999

APPENDIX 13

Memorandum by Association of Community Health Councils for England and Wales (PM 32)

EXECUTIVE SUMMARY

CHCs are the statutory representatives of the public's interest in the NHS. They also have contact with users of private health care services and would like to ensure that the protection they can provide is available to private patients. Nearly all CHCs are members of the Association of Community Health Councils for England and Wales (ACHCEW) which is also a statutory body.

The White Paper *Modernising Social Services* sets out plans to reform the regulation of care homes which are welcome. The regulation of the private acute sector also needs to be considered. The role of lay involvement in the work of the Commissions for Care Standards needs to be specified. CHCs should be given powers and resources to inspect private health care bodies, maintaining a local element to the inspection process.

Inspection reports should be made readily accessible to facilitate choice by the users of private health care services.

All private health care institutions should be required to operate complaints mechanisms involving elements of Local Resolution and Independent Review. Complainants need access to support and/or advocacy, which could be provided through CHCs, resources permitting.

INTRODUCTION: CHCs AND PRIVATE CARE

1. Community Health Councils were set up by statute in 1974 with the task of representing the public interest in the NHS in their local area. This followed scandals in long-stay care and recognised that the creation of Area Health Authorities did little to meet the need for public representation in the NHS. ACHCEW, the Association of CHCs for England and Wales, is also a statutory body, dating back to 1977, set up to provide a forum for CHCs, to provide information and advisory services to CHCs and to represent the user of health services at a national level. Community Health Councils are not obliged to be members of ACHCEW but at present 204 CHCs (out of 206) are in membership.

2. CHCs have developed to play three main roles:

- Advising individuals, in particular helping complainants through around 30,000 complaints every year as they struggle for explanations from NHS professionals and managers.
- Identifying the health care needs and aspirations of their communities, through the production of more than 2,000 publications (more than 140 reports in 1998 alone) and networking with voluntary organisations.
- Holding NHS bodies to account, by visiting hospitals and (with agreement) primary care settings, responding to consultation documents and demanding and scrutinising information from local NHS bodies.

3. CHCs do not have a statutory remit in relation to private care. However, they are approached by members of the public who wish to pursue complaints about private care. The NHS Executive encourages health authorities which contract with private institutions for the treatment of NHS patients to ensure that CHCs can visit the institutions. Some CHCs have visited private nursing homes with permission and produced guides to the homes operating in their area. Private patients do not enjoy the level of protection which CHCs can provide, which is of particular concern where the patients would use NHS services (eg long stay care) if these were available.

4. A number of relevant resolutions have been passed at General Meetings of the Association of CHCs.

5. In March 1997, a Special General Meeting endorsed ACHCEW's response to the review of CHC resourcing and performance management undertaken for the NHS Executive by the Insight management consultancy. This response stated:

"To ensure that the users of community care and long term care services have effective support, the Association recommends that:

- CHCs' monitoring rights should be protected as patients move from long stay hospitals into community homes.
- The managers of nursing homes and residential homes should be legally obliged to give CHCs such information about the planning and operation of their services as the CHC may reasonably require in order to discharge its functions.
- CHCs should have a statutory right to observer representation on all levels of joint commissioning between Health and Social Services, including Joint Consultative Committees, Joint Commissioning and Planning Teams/Groups (or their equivalent) and Joint Planning Teams (or their equivalent).
- The remit of CHCs should be extended so that they can support and represent social services complainants who have complaints that fall within the remit of the NHS and Community Care Act.
- In view of the growing number of people being placed in care homes, CHCs should have a statutory right to visit all private nursing homes, regardless of whether the health authority has a contract with them, and all residential care homes.
- CHCs should have the right to at least an annual meeting with representatives of social services departments, particularly those involved with community care policy and provision. This meeting might also include representatives from health authorities who have a similar key involvement.
- CHC should have the right to information from social services departments about plans and developments in care in the community.
- CHCs should be consulted about community care plans."

6. The 1998 AGM resolved:

"This AGM notes that:

the most dependent and vulnerable members of society have the added protection of CHC monitoring when they are in NHS premises;

- the intention of the Government was that this protection should not be lost when such patients are resettled in the community in non-NHS premises;
- the Guidance as expressed in *Consultation and Involving the Consumer* therefore required Health Authorities to secure CHC visiting rights in the contracts with non-NHS providers so that the protection followed the patient.

This AGM therefore calls upon the Government, as a matter of urgency, to reinforce this requirement so that this becomes an inalienable right attaching to the patient."

7. The 1998 AGM also resolved:

"This AGM calls on the Department of Health to review the position of patients living in nursing homes. At the present time these patients have no official representation from Community Health Councils unless their nursing home placement has been NHS funded. Patients in nursing homes are more often than not elderly, vulnerable and disempowered. They may hold back from complaining about inadequate or inappropriate care for fear of victimisation. This AGM expresses its grave concern about this group of patients, and calls on the Department of Health to:

- extend CHCs' rights to cover patients in nursing homes, irrespective of the source of their funding; and
- increase the resources available to CHCs to allow them to carry out these extra duties."

REGULATION AND INSPECTION

8. The Government has set out its plans to upgrade the registration arrangements for care homes in the *Modernising Social Services* White Paper.¹ ACHCEW welcomes the commitment to move towards a more consistent form of regulation and to ensure that the inspection regime is thorough and effective.

9. We share the concern expressed by the NHS Confederation that: "There needs to be a resolution as quickly as possible to the registration and inspection process for private/independent providers of acute hospital services, mental hospitals and hospices".² To ensure greater consistency across the country, it might be appropriate for these regulatory mechanisms also to be organised on a regional basis. There is a danger that health authorities with few private hospitals in their area may fail to develop sufficient depth of expertise. At the other extreme, some health authorities, particularly in central London, may have a large number of acute facilities without sufficient resources to do so. The Commissions for Care Standards may be able to take on this workload although parallel bodies are also a possibility.

10. *Modernising Social Services* states that the Government has no immediate intention to introduce new regulation for other service areas such as day care for adults. As North Hertfordshire CHC argues: “these centres will be serving the most vulnerable people in society, including the elderly and mentally ill, who need the full protection that registration and inspection arrangements can offer. As the Registration and Inspection arrangements are currently under review, it would seem a relatively simple matter for any impending change in legislation to be extended to cover the provision, registration and inspection of private Day Care Centres”.³

11. We are pleased that the Government has commissioned the Centre for Policy on Ageing to advise on proposed national standards for residential and nursing home care for older people. We welcome the commitment to consult on these standards which will “provide a basis for developing standards in other areas”. Users and their relatives and carers may find it hard to find substantial justification for differences in how national standards are interpreted by CCSs and in how they “define their own requirements within the limits of the national standards”. The boards will be appointed, not elected, and the accountability mechanisms to users and the public have not been spelled out in detail in the White Paper.

12. Without questioning the importance of other issues, we would stress that the following areas should be fully covered in inspections:

- Staffing issues in care homes are central to the task of inspection. Inspectors should be given evidence that homes have confirmed the registration of any newly appointed registered nurses directly with the UKCC. This is very important since all too often persons who have been removed from the register seek employment in the nursing home sector. Simple possession of a registration certificate should not alone be taken as a confirmation of current registration.
- South East Kent CHC has drawn attention to the importance of clinical audit and clinical governance procedures being implemented within private hospitals with the consultants involved being required to sign up to these procedures. This should be confirmed during inspections.
- Inspections should cover infection control measures.
- Inspectors will need to satisfy themselves that satisfactory complaints procedures are in place.
- Care homes should invite relatives and carers to attend announced visits so that they are given an opportunity to have some input to the reports. The inspectors should check to see if relatives have been invited to a pending visit.

13. It is essential that the regulatory bodies are sufficiently funded to make more than two inspections a year when they deem this desirable. As the Hertfordshire health authorities have warned, some homes require numerous visits: “some proprietors, admittedly (and fortunately) a minority, resist reasonable efforts to advise them on improvements to poor practice, sometimes with great hostility and dishonesty. They require numerous unannounced inspections over a short period of time in order to ensure that promised changes have been effected and, if not, to enable prompt action to be taken in the interests of residents. The risks to frail elderly people if such firm action is not taken are too great to allow for a less demanding approach”.

14. We welcome the White Paper commitment to user representation on the boards of the CCSs and hope this will be more than tokenistic. There should be more than one user representative on each board since solitary members can feel isolated and may lack the confidence which can be gained from colleagues sharing a similar perspective. In addition, relevant statutory and voluntary organisations should be invited to send representatives as observers with speaking rights.

15. The White Paper states that the inspectors will “consist of people with skills and qualifications from both social care and health care” and we hope that room will also be made for user representatives and advocates in the inspection teams. Responding to the 1995 consultation document on *Applying Citizen's Charter principles to the Registration and Inspection of Independent Nursing Homes*, ACHCEW was pleased that the contribution that lay people could make to inspection teams had been acknowledged. Recruitment of lay inspectors should be carried out with regard to equal opportunities. With this in mind, lay inspectors should be offered reasonable expenses such as caring and travel allowances. Some CHCs have a record of visiting private nursing homes and that expertise could be brought on board.

16. The NHS Management Executive's 1990 document *Consultation and Involving the Consumer* stated: “Where the DHA's [now, health authority's] residents are treated outside the CHC's own District, visiting rights are vested in the NHS in the CHC in the District of treatment. DHAs should secure similar visiting rights for CHCs to private sector premises through contracts”.⁴

17. CHC monitoring brings a specifically local focus as well as a lay perspective, drawing on links with voluntary organisations and local authorities. It also contributes to the CHC's awareness of relevant issues and informs its other work. As patients in NHS institutions enjoy the protection of CHC involvement, this should certainly continue to apply where the NHS pays for treatment or care in a private institution. There is also a strong case for CHC monitoring of bodies used by people who have been resettled in non-NHS establishments by the NHS or who would have used NHS facilities were these available. Patients and the public would however find it anomalous for CHCs to have visiting rights which relate to the funding or circumstances of individual patients (and which therefore would lapse when individuals are discharged or die). In addition, the removal of inspection functions from health authorities and local authorities creates a vacuum in local accountability and monitoring mechanisms which CHCs could fill. Indeed, CHCs should be empowered to visit, and require relevant information from, all health care providers in their area including

primary care facilities such as dental surgeries. It would not however be reasonable to place a specific obligation on every CHC without resourcing to match.

18. The Hertfordshire health authorities point out that under Part I of the Registered Homes Act, there is a requirement on home-owners to inform the regulatory authority of untoward incidents. This should also apply to nursing homes, “which would enable inspection units to monitor homes more effectively and ensure quality of care to a vulnerable and dependent client group”.⁵

REPORTING AND OPENNESS

19. Several Community Health Councils have produced guides to care homes in their areas or handbooks on how to choose between homes. These CHCs include Southport & Formby, South Buckinghamshire, East Berkshire and West Berkshire, Dewsbury, North Tyneside, Milton Keynes, Merton & Sutton, Wandsworth and Bradford. These publications have helped to fill a serious gap in the information available to help users and their carers to choose between homes. However, similar information needs to be available and easily accessible throughout the country and its collation should not be dependent on the co-operation of the managers or owners of the care homes involved. The Office of Fair Trading has drawn attention to the very limited choice exercised in practice when care homes are being chosen: in their survey, only 23.3 per cent of residents had received written information from a leaflet or brochure about their care home before moving in.⁶ Users and their families and carers need to be able to exercise informed choice to find the most suitable accommodation and care.

20. The present Government has brought nursing homes (and hospitals) in line with residential homes in that the reports of official inspections should now be available to the public. The *Guidance on Open Reporting of Nursing Home Inspections* states: “Reports do not have to be widely distributed on a routine basis, but information on how to obtain reports should be widely publicised via local sources such as Community Health Councils, voluntary organisations, libraries etc. Reports should be made available to members of the public on request and health authorities should normally be in a position to meet requests within two months of an inspection”. The following paragraph states: “Some health authorities may wish to produce summaries of inspection reports to give to the public. If authorities choose to do this, it must be made clear to the recipient that a copy of the full report can be made available on request and details of how to obtain the full report must be published”.⁷

21. We endorse the OFT’s recommendation that: “Inspection reports on residential homes and nursing homes should be widely available, easily accessible, clear and comprehensive. Inconsistencies between different authorities should be minimised”. The reports of inspections should therefore be easily accessible through public libraries, health authorities, voluntary organisations, CHCs, Citizens Advice Bureaux and the internet. This should apply to private hospitals as well as care homes. The Department of Health should monitor how long it takes the regulatory authorities to make reports available after inspections and how speedily they respond to requests for access or copies. Summaries of reports should be provided to users and carers but this would, of course, not reduce the importance of making the full reports easily available.

22. A Template for Open Reporting is included as an appendix to the official guidance on nursing home reports. Under “Complaints”, this suggests reference is made to: “Presence of complaints procedure, including recording of complaints, operation of procedures, and level of knowledge by residents/relatives (mention may be made here of any complaints on regulation issues made to the registration authority since the last inspection which have been fully or partly upheld; and of any legal actions taken by the registration authority against the Home/Proprietor since the last inspection”. While this is welcome, the reports could also give information on the number and type of complaints received. ACHCEW also suggests that inspection reports should be specific about:

- the qualifications and training of the staff employed;
- clinical audit and governance procedures;
- infection control measures followed; and
- any untoward incidents reported to the registration authority.

23. Consideration should also be given to the scope for requiring greater openness through the registration system. One possibility would be to require each institution to make available a booklet with a specified minimum content (analogous to GP practice leaflets). The OFT suggests brochures should include “clear and comprehensive information” about “care and facilities”, the fees charged and what they include, the cost of facilities not covered by the fees, key contract terms and conditions and the “internal and external complaints procedures”. Also: “All bodies providing information should consider offering that information in large print or braille, or an audiotape”.

24. Statistical monitoring in relation to a set of performance indicators would also be appropriate, adapting indicators in use for NHS institutions as appropriate.

COMPLAINTS

25. The importance of an effective complaints machinery has been highlighted by the General Medical Council's decision to strike Rodney Ledward, the Kent gynaecologist, off the medical register. South East Kent CHC hosted a meeting for former patients of Mr Ledward on 16 November 1998. Approximately half the women attending had received private treatment and felt unable to acquire adequate support because they were outside the NHS. Many said they had been persuaded to be treated privately as Mr Ledward had informed them, incorrectly, that the procedure in question was either unavailable via the NHS or that the waiting list was so long as to put them at great risk. The clear message was that an independent public inquiry was required to restore public confidence to answer a range of questions including:

- Why is there no regulatory body to monitor clinical practice in private hospitals?
- Why is there no apparent formal complaints procedure open to patients in private hospitals?
- Why isn't the East Kent Health Authority, as registering authority, allowed access to information regarding numbers and types of operations performance at private hospitals within its district?

In the Adjournment Debate on 10 December, Michael Howard MP paid tribute to the work of the CHC's Chair and Chief Officer and agreed with the CHC—"an authoritative and serious body"—that a public inquiry was necessary. The CHC has been gathering evidence for the Health committee inquiry.

26. Complaints mechanisms are necessary to ensure that users' concerns are addressed. They can help providers to improve their services as well as reassuring the users that lessons have been learned. ACHCEW argues that complaints mechanisms should have the following characteristics:

- Visibility: any complaints procedure must be widely publicised within hospitals and doctors' surgeries and within the wider community.
- Accessibility: patients with a complaint should be able to lodge their complaint with someone in authority with the minimum of difficulty.
- Speed: a speedy resolution to complaints is in the interests of not only the complainant but also those who are being complained about.
- Impartiality: clearly if patients are to have any faith in a complaints procedure then it must be seen to be impartial.
- Effectiveness: any complaints procedure must address the major concerns of patients, which are to find out what happened,

27. The social services White Paper promises: "We will consider in establishing the CCSs how best to ensure complementarity and coherence between the various complaints procedures that apply to care homes and other regulated services". Reforms are needed to ensure that throughout private health care—including areas outside the remit of the CCSs—complaints procedures are established which meet the above criteria. The Office of Fair Trading has set out the labyrinth of different complaints routes which at present apply to differently funded residents of care homes (and private hospitals).

28. The Residential Care Homes Regulations 1984 require residential care homes to provide complaints procedures. However, no equivalent requirement is laid down in the Nursing Homes and Mental Nursing Homes Regulations. All registered homes and acute facilities should be required by law to operate complaints procedures.

29. The Office of Fair Trading points out that inspection units investigate complaints "mainly to collate evidence and determine whether the care-home owner is a fit person to run the home, and in order to raise and maintain standards". Patients in private hospitals can make complaints to the registering health authority in relation to the issues considered in registration. NAHAT's 1993 supplement on *Independent Acute Hospitals and Services* to the *Handbook on the Registration and Inspection of Nursing Homes* states that applicants for registration need to provide information on "the complaints procedure which should include a reference to the patient's right of access to the registering authority on matters relating to the registration of the hospital".⁸ However: "The health authority has no standing in relation to the care relationship between an independent clinical consultant and his or her patient unless an issue arises relevant to the duties of the registering authority under the Registered Homes Act 1984". While this severely restricts the scope of investigations by registering authorities, the mechanism does at least allow patients to have complaints considered by authorities outside the private hospital.

30. A consistent and coherent framework is overdue. ACHCEW suggests that there may be a case for requiring as a condition of registration that all providers operate complaints mechanisms based on the NHS procedure, ie incorporating a Local Resolution stage and an Independent Review stage. At Local Resolution, the complaint would be considered within the provider concerned. However, if complainants do not receive a response they consider to be satisfactory, there should be scope for having their complaint subject to some form of independent assessment. There is a logic to this Independent Review stage coming within the remit of the regulatory authority, ie the CCSs for care homes and the relevant agencies for hospitals and other private providers. Assuming that the Independent Review stage is reasonably thorough and therefore resource-intensive, it is likely that patients will not be given an automatic right to take their complaint to Independent Review. As in the NHS procedure, an Ombudsman could be empowered to consider refusals to allow a case to go to Independent Review and to hear appeals against the conclusions of Independent Review.

31. In the acute sector, there is a particular problem in that the private hospitals are not responsible for the standards achieved by the consultants who use their facilities. It may therefore be difficult for patients to obtain satisfaction in relation to the quality of medical care they receive or the appropriateness of the consultant's behaviour. This problem certainly needs to be addressed. It should be a condition of registration that each hospital operates a complaints procedure covering all aspects of care received at the hospital, including those for which the consultant is responsible. (This might need to be specified in the agreement between the hospital and the consultant.) Assessment of contentious cases at Independent Review stage would allow questions to be raised about the effectiveness of Local Resolution procedures and the willingness, in any suitable cases, of the provider to deny use of its facilities to consultants who fail to co-operate fully.

32. For a complaints system to be fair and effective, complainants must be able to access support and/or advocacy. Without support, some users will be reluctant to complain at all and others will feel short-changed, bullied or out-manoeuvred. The OFT reports: "The fear of victimisation or other unwelcome attention was a further underlying theme in the response of many residents, relatives, and charities". Meanwhile, former patients of private hospitals may be sceptical about the prospects of obtaining satisfaction.

33. Community Health Councils are the primary port of call for support to complainants in relation to the NHS complaints procedure, assisting complainants with around 30,000 complaints pa. Their staff have a wealth of experience and, given sufficient resources, would be well-placed to assist complainants in the private sector. This would have the additional advantage of informing the CHCs' monitoring of private institutions and, indeed, of the consultants who work in both sectors.

34. Statistical monitoring will be essential to allow users to make informed choices and to draw attention to providers or individual professionals who are frequently complained against. We suggest that registered homes and hospitals, operating a two-stage procedure in line with the NHS procedure, should be required to submit statistical data in the same way as NHS providers. This includes breakdowns in relation to: the level of the procedure reached; the proportion of complaints resolved within the performance target period; service area; profession/staff category; and main subject of complaint. Every year the Department of Health should publish the information collected naming the providers involved.

35. In addition, there should be a system for collecting data by name for every health care professional complained about. It would not be appropriate for this information to be collected only at the level of the local or regional registration body (unless the information was subsequently shared across all the registration bodies in the country). The information should be copied to the relevant professional regulatory body which would be empowered to have access to all records kept by the providers in relation to the complaints considered. They would also be required to inform relevant providers (including NHS employers of consultants) as soon it is decided to refer cases for consideration by the appropriate regulatory committee.

36. Complaints mechanisms need to be established across the field in private health care, as they have been in the NHS. There is, for example, a clear need to establish comprehensive complaints procedures for dental services.

CONCLUSIONS

37. Private patients and users of private care institutions at public expense should have the confidence that these institutions are subject to a thorough and consistent form of regulation and operate meaningful complaints procedures. These patients should also have access to information to enable them to exercise choice when they wish to do so.

38. The Government's White Paper on *Modernising Social Services* is an encouraging start to reforming the present arrangements. Arrangements for the private acute medical sector are now urgent. It is also important to ensure effective lay involvement in the regulatory system and support to people who wish to pursue complaints about the care they have received.

January 1999

REFERENCES

1. Department of Health, *Modernising Social Services*, Cm 4169, 1998.
2. NHS Confederation, *Modernising Social Services*, Briefing No. 25, December 1998.
3. Correspondence with ACHCEW.
4. NHS Management Executive, *Consultation and Involving the Consumer*, 1990.
5. East & North Hertfordshire Health Authority and West Hertfordshire Health Authority, *Representation to the Government on Aspects of the Registered Homes Act 1984 and Department of Health Guidance on Regulation* (unpublished), 1996.
6. Office of Fair Trading, *Older People as Consumers in Care Homes*, 1998.
7. NHS Executive, *Open Reporting of Nursing Home Inspections*, HSC 1998/047.

8. National Association of Health Authorities and Trusts, *Independent Acute Hospitals and Services*, supplement to *Handbook on the Registration and Inspection of Nursing Homes*, 1993.

APPENDIX 14

Memorandum by East Kent Medical Services Ltd (PM 33)

1. INTRODUCTION

1.1 EKMS is a company which has funded, developed and operates the 22 bed Spencer Wing, a Private Patients Unit on the site of the Queen Elizabeth, The Queen Mother Hospital, Margate. The QEQM Hospital is a part of Thanet Healthcare NHS Trust.

1.2 The Spencer Wing is mainly used for the private practice of Consultant Medical Staff employed by the Trust. The Medical Advisory Committee, chaired by Ian Stephen, consists of consultant medical staff users, and advises the Company on all clinical issues.

1.3 The Spencer Wing was a PFI development which also contains a Postgraduate Medical Education Centre for use by medical and professional staff including GP's. The ethos behind the development was to provide a centre for private practice and medical education which would enable the Trust to recruit and retain top quality medical and other professional staff for the benefit of NHS patients.

1.4 The development and modus operandi of The Spencer Wing is the subject of a comprehensive Operating Agreement between EKMS and the Trust which prescribes standards of operation, quality, regulation and inspection required by the two parties.

2. EVIDENCE

2.1 The definition of "Private and other Independent Healthcare" is broad, and needs to be categorised to differentiate between sectors. We contend that the provision of private healthcare facilities on NHS Sites in Private Patients Units should be viewed as a distinct sector which is quite separate from, for example, independent hospitals, nursing homes, etc.

2.2 Private Patients Units operates as part of, or in close co-operation with the NHS host site. Many services are shared for the benefit of both parties. Many practical difficulties would arise from the Private Patients Unit being regulated by a different body from the NHS Trust.

2.3 Private Patients Units on NHS sites should be regulated, monitored and inspected by the NHS Trust in accordance with protocols, quality standards and accreditation requirements applying to the host hospital.

2.4 Standards should be agreed and formalised in an Operating Agreement which should be signed by the Trust, the consultant medical staff and the Manager/Operator of the Private Patients Unit.

2.5 Complaints procedures for Private Patients Units on NHS sites should be based upon and agreed with the host NHS Trust.

3. RECOMMENDATIONS

3.1 Private Patients Units in NHS hospitals should be subject to different regulations than other non-NHS facilities.

3.2 Regulation, monitoring and inspection should be the responsibility of the host NHS Trust and should comply with relevant NHS regulations and accreditation requirements.

January 1999

APPENDIX 15

Memorandum by South East Kent Community Health Council (PM 34)

EXECUTIVE SUMMARY

This report details those areas of private and independent healthcare regulation and practice, which are of cause for concern to South East Kent Community Health Council.

Many of these concerns have arisen through the Council's involvement in the "Rodney Ledward case", which it believes is relevant to this inquiry. The Committee may well be aware that Mr Ledward, who worked as a gynaecologist in South East Kent between 1980 and 1996, was removed from the register of the General Medical Council in September 1998.

Since November 1998, the Community Health Council has been in correspondence with over 100 former patients who were treated in the private sector. Their stories, some of which are detailed in the Appendix to

this report, provide compelling evidence for the need to review the adequacy and extent of the regulation, monitoring and inspection of healthcare outside the NHS.

The main concerns, which the Community Health Council seeks the Health Committee to investigate, can be summarised as follows:

- The need for statutory and regulatory compliance with nationally recognised Clinical Audit and Clinical Governance systems for hospitals, medical practitioners and private health insurance companies operating in the private health sector.
- Clarification on the lines of accountability and responsibilities of all medical and nursing staff and managers working in the private health sector to patients who are dissatisfied with the service they have received.
- Clarification on the responsibilities/liability of private health insurance companies and all hospitals providing private health care upon receipt of complaints.
- The need to introduce nationally recognised and accredited complaints and independent appeals procedures for the benefit of patients in the private sector, and access to an independent arbiter such as the Health Service Ombudsman.
- The need to review the ownership of, and access to, medical records of procedures and consultations carried out in the private health sector.
- Guidance on the types and quality of information and documentation provided on a patient's discharge from a private hospital.
- The role of the Royal Colleges and other professional bodies in monitoring the performance of doctors working in the private sector and in dealing with complaints received about the competence of individual members.
- The need to provide relevant information to local health authorities on the inpatient activity at private hospitals within their district.
- The role of health authorities in the registration and inspection of private hospitals and the monitoring of clinical audit and clinical governance procedures within those hospitals.

1. CLINICAL GOVERNANCE

1.1 It appears that there are no formal regulatory clinical governance requirements within the private health sector along the lines of the framework that has been developed in the NHS.

1.2 The South East Kent Community Health Council believes that, in order to safeguard patients, both private hospitals and NHS hospitals should be obliged, by statute and regulation, to have clinical governance systems in place. *Please refer to Appendix 2.*

1.3 Many doctors who work in private hospitals act as independent practitioners and are not employed by those hospitals and appear to have informal relationships with private health insurance companies to provide healthcare for their policy holders.

1.4 The South East Kent Community Health Council recommends that private hospitals should be required to set up clinical governance and clinical audit procedures, which are all encompassing to include the activities of medical practitioners and the outcomes of those activities.

1.5 This should involve a multi-disciplinary peer review where participants can be safe in the knowledge that their findings will be treated as credible and the culture of "whistle blowing" may become a thing of the past.

1.6 Furthermore, doctors working within those hospitals should, in order to secure their "preferred provider" status with private health insurance companies, be required to "sign up" to recognised clinical audit and clinical governance procedures.

1.7 These measures would help hospitals and private health insurance companies to identify concerns about poor performance at an early stage and take appropriate action. *Please refer to Appendix 1.*

1.8 Health authorities are responsible for the registration of private hospitals. The apparent lack of clinical governance systems in the private sector, however, makes it difficult for health authorities to assess the quality of the services and treatment provided at those hospitals.

1.9 This Community Health Council believes that, as health authorities are responsible for the registration and inspection of private hospitals, they should therefore be required to take responsibility for monitoring clinical audit and clinical governance within that sector.

2. LINES OF ACCOUNTABILITY

2.1 On 16 November 1998, the South East Kent Community Health Council hosted a public meeting which was attended by more than 250 people who either were, or were friends/relatives of, Mr Ledward's former patients. It was clear that there was a great deal of confusion among the audience regarding the

administrative, clinical, ethical and legal responsibilities of the various agencies involved and their inter-relationships with the NHS.

2.2 The Community Health Council supports the view held by many of those patients that the following questions need to be addressed:

- What responsibilities does a private health insurance company have to its client when that client makes a complaint about treatment provided under its policy?
- Where may a client go if (s)he is dissatisfied with the response of that company? *Is this a health issue or an issue for the Insurance Ombudsman?*
- What are the responsibilities of the General Medical Council, the Royal Colleges and other professional institutions in terms of the continued accreditation of clinicians under their registration?
- What are the methods of investigation used by those institutions upon receipt of complaints regarding the competence of their individual members?
- What responsibilities do private hospitals have to patients using their services when a complaint is made about treatment provided by an independently contracted consultant at that hospital, and how do they deal with complaints?
- What responsibilities do NHS Trust personnel have to patients using their services on a private basis when a complaint is made about care and/or treatment provided at that hospital?
- Do private patients have full access to the NHS complaints procedure in respect of treatment provided within an NHS facility, and does this include the activities of the medical practitioner concerned?
- What responsibilities do NHS Trust personnel have, in terms of reporting poor performance, when patients are transferred direct from private hospitals, via Accident and Emergency units, for remedial treatment or surgery?

3. COMPLAINTS PROCEDURE

3.1 Whilst the effectiveness and fairness of the NHS Complaints Procedure is often questioned by patients, it is accessible, clearly defined and is open to appeal and subject to independent scrutiny.

3.2 Private hospitals are required, under the terms of their registration with local health authorities, to have complaints procedures in place. Such procedures are, however, internal and are not subject to independent review or scrutiny by the Health Service Ombudsman.

3.3 Once a private hospital has investigated a complaint and decided what action needs to be taken, there appears to be no appeal or independent arbitration system available to the complainant.

3.4 NHS patients, however, may utilise the services of their local Community Health Councils who can provide information and advice about the NHS complaints procedure. Where necessary, Community Health Council staff may also help complainants to prepare letters and support them at meetings with NHS managers and clinicians. Such services are available free of charge to the complainant and can help to achieve a mutually satisfactory outcome, without recourse to pursue expensive, and often, inappropriate, litigation.

3.5 The South East Kent Community Health Council believes that any person receiving healthcare in the private/independent sectors, should have access to a nationally accredited complaints procedure similar to that which exists in the NHS. This should include a similar appeals process and be subject to the independent scrutiny of the Health Service Ombudsman.

3.6 It is also recommended that the Committee explores the possibility of extending the remit of Community Health Councils to include providing a complaints information and advice service to patients in the private health sector.

4. MEDICAL RECORDS

4.1 At the public meeting hosted by South East Kent Community Health Council on 16 November 1998, issues relating to medical records were frequently raised. One of the most common complaints expressed by both patients and representatives of South Kent Hospitals NHS Trust, who had offered to review the medical records of concerned patients, was that many of the relevant records were missing.

4.2 Patients were advised that, in the private sector, records of consultations and surgical procedures, which might well be of vital importance to other clinicians, were not the property of the hospital or the patient but the consultant.

4.3 Consultants at South Kent Hospitals NHS Trust have, since September 1998, held consultations with over 200 of Mr Ledward's former patients. Not only have many of the records gone missing but often those that remain provide inadequate information on what procedures were carried out, details of complications and, perhaps most importantly valid reasons for performing surgery in the first place (*please note Appendix 1*).

4.4 The importance of current, accurate and detailed medical records, particularly in respect of patients requiring continuing care, should not be understated. Recent initiatives in the NHS include computer “tracking” of case notes so that the location of a patient’s notes may be identified at any given time.

4.5 The South East Kent Community Health Council believes there is a need to review the ownership and maintenance of private health records, in order to protect the patient.

4.6 This should include measures to introduce regulations/legislation to ensure that records are made contemporaneously and copies are retained within the hospital. These records should then be accessible to NHS medical practitioners and the patients themselves.

4.7 It is also recommended that guidelines be introduced on the types and quality of information to be provided on medical records and discharge advice letters in order to facilitate appropriate healthcare in both the private and NHS sectors.

5. THE PROVISION OF RELEVANT DATA AND HEALTH INFORMATION

5.1 Health authorities have a statutory responsibility to collect relevant data in order to identify local health trends and needs and thereby appropriately commission NHS services and allocate NHS resources. At present, however, health authorities may only obtain and present a partial view of the healthcare activity in their respective areas.

5.2 Private healthcare providers are not required to provide details of activity within private hospitals or clinics. South East Kent Community Health Council believes that private hospitals should be obliged to furnish local health authorities with relevant data on inpatient activity and this should include details of the numbers and types of operation performed, patient age groups and outcomes.

5.3 This would help health authorities to produce a more accurate epidemiological profile of the local population. Such information is important in the quest to reduce inequalities in health as current statistical data may be skewed by the exclusion of private treatment, which tends to be more accessible to more affluent socio-economic groups.

5.4 The publication of the types of information suggested in paragraph 5.2 would also enable patients in the private sector to make an informed choice about which doctor would be the most appropriate for their needs.

CONCLUSION

The main concerns, which the Community Health Council seeks the Health Committee to investigate and address, can be summarised as follows:

- The need for statutory and regulatory compliance with nationally recognised Clinical Audit and Clinical Governance systems for hospitals, medical practitioners and private health insurance companies operating in the private health sector.
- Clarification on the lines of accountability and responsibilities of all medical and nursing staff and managers working in the private health sector to patients who are dissatisfied with the service they have received.
- Clarification on the responsibilities/liability of private health insurance companies and all hospitals providing private health care upon receipt of complaints.
- The need to introduce nationally recognised and accredited complaints and independent appeals procedures for the benefit of patients in the private sector, and access to an independent arbiter such as the Health Service Ombudsman.
- The need to review the ownership of, and access to, medical records of procedures and consultations carried out in the private health sector.
- Guidance on the types and quality of information and documentation provided on a patient’s discharge from a private hospital.
- The role of the Royal Colleges and other professional bodies in monitoring the performance of doctors working in the private sector and in dealing with complaints received about the competence of individual members.
- The need to provide relevant information to local health authorities on the inpatient activity at private hospitals within their district.
- The role of health authorities in the registration and inspection of private hospitals and the monitoring of clinical audit and clinical governance procedures within those hospitals.

CASE STUDIES

MRS ANN RHODES

In 1992, Mrs Rhodes was diagnosed by her GP as having fibroids. She was referred to Mr Ledward at Deal Hospital as an NHS patient. He confirmed the diagnosis, but said that on the NHS she would have at least a year's wait for an operation and that the only option was to consider a private operation at St Saviour's Hospital, which could be done immediately, or to suffer regular D&Cs with the subsequent sick leave from work each time.

Mr Ledward made it clear that the NHS operation would not be able to be brought forward just because she would often need to have a D&C and convinced her that, because her job was such that she could not afford to be regularly on sick leave without losing her particular post, that the only real recourse was to opt for private treatment.

Mrs Rhodes felt she had no choice and received an appointment for one week later for Mr Ledward to operate on her at St Saviour's Hospital. The operation cost her £3,340. The only procedure she expected to have was a hysterectomy. When she came around from the operation, Mr Ledward told her that her ovaries were healthy, but he had taken them out at the same time as *"You won't be needing them any more, will you? And it saves going back in there again if there are problems"*. It seems that she had in fact signed for an oophorectomy as well as the hysterectomy, but she did not understand the word *"oophorectomy"* and no one had explained it to her.

MRS EILEEN PIDDOCK

Mrs Piddock first saw Mr Ledward in April 1980 at an Outpatient clinic at the Royal Victoria Hospital, Folkestone as an NHS patient. She had been suffering from lower back pain and period pain. Mr Ledward advised a D&C, but said there was a long waiting list, about two years. Mrs Piddock told him that she had just joined the BUPA Medical Scheme and said that his whole attitude immediately changed.

A few days later, Mrs Piddock was admitted to St Saviour's Hospital as a private patient. Following the D&C, he advised a hysterectomy as she had an *"enlarged uterus"*. She had this operation, following which she haemorrhaged and had to be taken back to theatre. She also developed a wound infection. Mrs Piddock subsequently developed an ovarian cyst and found that she was leaking urine. Mr Ledward's explanation to her was that *"this sometimes happens after a hysterectomy"*.

Mrs Piddock was readmitted to St Saviour's Hospital and Mr Ledward carried out a repair operation on her bladder. This was not successful and in fact made her incontinence worse. Mr Ledward readmitted her to St Saviour's Hospital for another procedure on her bladder. Following this procedure, Mr Ledward told her she would be fine, but in fact her incontinence deteriorated still further. She was then referred to a Urologist who carried out urodynamic studies. The Urologist carried out three further operations on her bladder and she is still undergoing investigation.

At an appointment with one of the Trust's consultants, she was told that it was not clear from her notes why she required a hysterectomy.

MRS PAULA ANDERTON

Mrs Anderton was referred to Mr Ledward in 1983 under the NHS for infertility problems. Mr Ledward informed her that she required surgery and that the waiting list on the NHS was at least two years and that it would be in her best interests to have the operation done privately at St Saviour's Hospital. Mrs Anderton agreed and all her subsequent treatment was carried out privately and paid for by her health care plan. She had operations in 1984, 1986 and 1988.

In 1991, Mrs Anderton had an annual scan, which showed that she had an ovarian cyst. Mr Ledward arranged for her to be admitted to the William Harvey Hospital to have an operation the following week as a private patient. The procedure was to be quite straightforward, that is the removal of a cyst.

During the course of the procedure, it would seem that a cut was made in Mrs Anderton's bowel. It is Mrs Anderton's understanding that no notes were made regarding this complication and that the medical staff (SHO, Registrar and Nurses) were not informed of it. When she became seriously ill, they were totally unaware of the cause and how to treat it. They were unable to contact Mr Ledward and he did not come to see her until her fifth post-operative day. By this time, she was losing faeces from the hole in her abdomen.

When Mr Ledward appeared, he told Mrs Anderton's family that, during the operation, he had torn a hole in the bowel and tried to repair it and that it must now be emptying inside her and it must have caused a fistula to her abdominal scar. She then had to undergo a prolonged period of parenteral nutrition to enable the bowel to heal. Faecal matter continued to drain from the fistula and Mrs Anderton had to wear a colostomy bag.

Mrs Anderton was finally discharged from hospital almost two months after the operation. On her return home, she was still extremely ill and debilitated. She continued to suffer nausea, sickness, abdominal pains and diarrhoea. The fistula still hadn't healed. On 19 July, she was admitted as an NHS patient to Buckland Hospital under Mr Derry for the closure of the fistula.

MRS GINETTE RODESANO

Mr Ledward first treated Mrs Rodesano in 1984. Her previous medical history included a total abdominal hysterectomy in 1975 and division of adhesions in 1977. All her previous treatment had been under the NHS, but as she had the benefit of private health insurance Mr Ledward suggested that he would treat her as a private patient. All her subsequent treatment for Mr Ledward was as a private patient.

Later in 1984, Mr Ledward re-operated and removed Mrs Rodesano's right ovary. This was followed by an operation in 1985 to remove her left ovary and insert a hormone implant. In 1986, she had a further laparotomy and hormone implant and the procedure was repeated in 1987, July 1988, July 1989 and March 1990. In September 1990, Mrs Rodesano was admitted to St Saviour's Hospital under Mr Ledward for a laparotomy plus drainage of a torsion cyst and division of adhesions. By her fourth post-operative day, she was suffering abdominal pain. She then started to leak faecal fluid from the abdominal wound.

She was taken down to theatre by Mr Ledward and when she came back she had an open wound with a drain inserted into it with foul smelling fluid draining from the wound.

Mr Ledward told her that he had punctured her bowel and that another Surgeon was to be called in to operate on her. On 13 September 1990, Mrs Rodesano was taken back to theatre and operated on by Mr McPartlin. Part of her bowel was removed. Mr Ledward came to see her dressed in jodhpurs and riding boots. She was discharged from hospital three weeks post-operatively still feeling extremely weak and debilitated.

On her return home, she had to be admitted as an emergency to the Luton & Dunstable Hospital because she had developed an obstruction in her bowel. Since then, she says that she has experienced pain every day. She has been advised that the pain is caused by adhesions from so much surgery, but that if she is operated on again to divide the adhesions then that will only exacerbate the problem.

Annex

RE: CLINICAL GOVERNANCE (PARAGRAPH 1.2)

We welcome BUPA's commitment to the government to match the NHS clinical governance framework and we recognise that their hospitals already have in place clinical quality assurance measures, which include care-pathways, audit and outcome measurement.

APPENDIX 16

Memorandum by Norwich Union Healthcare (PM 37)

1. NORWICH UNION HEALTHCARE

1.1 Norwich Union Healthcare entered the private medical insurance (PMI) market in 1990 and has grown rapidly to become the third largest insurer with 9 per cent market share. On behalf of our customers we currently purchase in excess of £110 million of healthcare from the acute sector.

1.2 From a healthcare provision perspective Norwich Union Healthcare's interest is in purchasing high quality cost effective healthcare for our customers.

2. THE PRIVATE SECTOR

2.1 While the private sector in the UK is smaller than in many other OECD countries it is still a significant contributor to overall healthcare provision. Currently consumer spending on healthcare (including expenditure on pharmaceutical products without an NHS prescription) accounts for 13 per cent of total healthcare spending.

2.2 Within the private market Norwich Union Healthcare's prime concern is the acute sector. This sector accounts for one in six of all acute inpatient operations undertaken in the UK. The vast majority of this work is funded by insurance, a market which itself is worth some £2 billion or 4 per cent of total healthcare spending.

2.3 The experience of Norwich Union Healthcare and its customers is that this sector currently provides a high quality of clinical care and service. Despite funding in excess of 50,000 inpatient and daycare episodes a year we experience minimal complaints about clinical quality. While the current regulation of the sector is limited and quality standards are fragmented and ad hoc, there is much proxy evidence to support the quality of private sector work. In particular, private patients are treated quickly by high quality staff, in high quality

facilities (often with BSI or King's Fund quality accreditation) and in single rooms which helps minimise the risk of cross infection.

2.4 Despite this, Norwich Union Healthcare believes that the consumer can be better serviced by a more formal system of regulation.

3. REGISTRATION OF HOSPITALS AND OTHER FACILITIES

3.1 Current registration requirements for healthcare facilities are very limited and are of little use to the consumer. There is no formal requirement for registration of NHS hospitals or any other NHS establishment. Private hospitals are registered under the Registered Homes Act but other private facilities are not.

3.2 Consumers should have the benefit of independent assessment of the facilities they are using for their healthcare treatment. This applies to public or private patients in public or private facilities.

3.3 Norwich Union Healthcare recommends that a formal system of inspection and registration for both NHS and private facilities is required. Initially this should apply to hospitals and should be extended to other facilities as appropriate. It is key that both private and public facilities are regulated under the same system. Registration should be undertaken by a body independent of both the public and private healthcare sectors.

4. CLINICAL QUALITY

4.1 Current systems for monitoring clinical quality in the private sector and public are ad hoc and fragmented. In addition little information for the consumer to make informed choices about the quality of available doctors, appropriate treatments and facilities.

4.2 The NHS is establishing a framework for setting and monitoring clinical standards. These same standards and framework should apply to the private acute sector. From a consumer perspective this is key in delivering consistent and comparable information. This is particularly important since most private patients will also be NHS patients. It is also illogical, when such a large percentage of acute work is delivered within the private sector, if the quality standards do not embrace both sectors.

4.3 Norwich Union Healthcare therefore recommends that the private acute sector is brought within the same framework as the NHS for setting and monitoring clinical quality. This should include performance measures for clinicians that pool results from both NHS and private practice. In addition, we believe that as much information as possible out of this framework should be made available to consumers, enabling them to make informed choices.

5. COMPLAINTS

5.1 The financial services industry has had a recognised system of dealing with complaints via an Ombudsman for many years. Norwich Union Healthcare belongs to the insurance Ombudsman scheme and only one major PMI insurer is not a member. This provides an independent and fast system for resolving complaints. This service is free to the consumer. Whilst decisions are binding on the insurer they are not binding on the consumer. No such scheme is in existence for complaints against doctors or hospitals in the private sector.

5.2 Because of the fundamental differences between the NHS and the private sector, extending the NHS Ombudsman scheme to the private sector is almost certainly inappropriate. However, there is a need for a comprehensive and independent complaints system in the private sector covering all private providers. This should enable customers of the private sector, who have complaints against either doctors or hospitals, to have an independent body investigate the complaint and recommend a decision which is binding upon the private provider. Such a process would not affect consumers' normal rights under the law. Norwich Union Healthcare recommends that such a process is established.

6. SUMMARY

6.1 The private sector makes a valuable contribution to the overall healthcare of the nation.

6.2 There is much evidence that the care delivered within the private sector is of the highest quality. However, current regulation of both public and private sectors is fragmented and limited in its scope.

6.3 Norwich Union Healthcare therefore recommends:

6.3.1 An independent system of inspection and registration for public and private healthcare facilities.

6.3.2 That the private sector is brought within the scope of the current frameworks for measuring and monitoring clinical quality being established in the NHS.

6.3.3 A comprehensive complaints system covering private sector provision is set up along the lines of an ombudsman scheme.

6.4 Norwich Union Healthcare believes that these proposals will be of real value to consumers when they are making decisions about private treatment. They will also ensure that all necessary safeguards are in place and the public and private sectors are meeting the same high standards.

January 1999

APPENDIX 17

Memorandum by the National Council for Hospice and Specialist Palliative Care Services (PM 39)

1. BACKGROUND

1.1 *Numbers of Voluntary Hospices*

There are currently 187 voluntary hospice units and teams in England, Wales and Northern Ireland.

	<i>Adult Hospices</i>	<i>Children's Hospices</i>
England	160	15
Wales	8	—
Northern Ireland	4	—

1.2 *Range of Services*

They provide a range of services designed to meet the palliative care needs of patients with cancer and other life-threatening illnesses together with their families. Adult hospices are concerned principally but not exclusively with the care of patients during the last year of life. Children's hospices tend to have a longer association with their patients and families.

The services provided include in-patient care, day care, home care, out-patient clinics, bereavement support and palliative care support within hospitals and other services managed by NHS Trusts. They are delivered by multi-professional specialist palliative care teams consisting of doctors, nurses and social workers supplemented by trained volunteers and increasingly by physiotherapists and occupational and diversional therapists. The services are provided without charge to patients.

1.3 *Definitions of Palliative Care*

All services are based upon the palliative care approach which contains the following principles of care:

- Focus on quality of life which includes good symptom control;
- Whole-person approach taking into account the person's past life experience and current situation;
- Care which encompasses both the person with the life-threatening disease and those that matter to that person;
- Respect for patient autonomy and choice (eg over place of care, treatment options);
- Emphasis on open and sensitive communication, which extends to patients, informal carers and professional colleagues.

Specialist palliative care is the active total care of patients with progressive, far-advanced disease and limited prognosis, and their families, by a multi-professional team who have undergone specialist palliative care training.

1.4 *Integration of Services with the NHS*

The voluntary hospice services have become increasingly well integrated with the NHS. The NHSE Executive Letter EL(94)14 called upon health authorities to “*develop local strategies for specialist palliative care based on needs assessment in collaboration with other relevant bodies and palliative care providers, including the voluntary sector.*” This advice has been repeated and reinforced by EL(95)22 and EL(96)85 which gave guidance on the integration of palliative care into cancer services in the light of the Calman/Hine report on cancer service reorganisation.

Nearly all voluntary hospices have service agreements with health authorities for the provision of specified palliative care services. The average funding contribution of the NHS to the costs of those services is around 32 per cent with the remainder of the running costs being funded from charitable sources. In the current year in England the adult hospices are budgeting to spend around £195 million of which the NHS contributes £63 million. The range of contribution is between zero and 61 per cent.

Although the relationship between the voluntary sector and the NHS has become very close in recent years the hospices remain independent charities usually incorporated as companies limited by guarantee without share capital.

2. CURRENT ARRANGEMENTS FOR REGULATION AND INSPECTION

2.1 *Registered Homes Act 1984*

Voluntary hospices are regarded as nursing homes and regulated and inspected as such under the above Act. They are however very different from nursing homes as Section 1 demonstrates—different in philosophy, function, staffing, funding and integration with the NHS. They are also not the patients’ homes. The mean percentage of in patient stays per unit ending in discharged in 1997–98 was 49.5 per cent. In that sense hospices function more like hospitals than nursing homes.

The Chief Executive of a hospice who at one time was an Inspector of Nursing Homes identifies a number of other differences;

- The ratio of qualified to unqualified staff is usually higher in hospices compared to nursing homes because of the nature of the care being given ie high levels of skilled nursing care because of the psychological and physical dependency of patients and the support needed by relatives.
- Medical cover is usually provided by specialist doctors rather than local GPs.
- Other members of the multi-professional team are integral to patient care eg physiotherapy.
- Acute treatments are given eg drainage of ascites, setting up syringe drivers, giving epidurals.
- Range and types of drugs is wider with a higher number of controlled drugs compared to nursing homes.
- Higher numbers of patients receiving oxygen.

2.2 *Other Forms of Monitoring*

All hospices which have service agreements within the NHS are subject to monitoring in varying degrees of those agreements by the NHS commissioning agency concerned. In the North West Region the Regional Office of NHSE has developed accreditation criteria for palliative care units which are providing services as part of local cancer services. These criteria will apply to both NHS and voluntary units. This development may well be replicated in other NHS Regions. Some hospices have elected to have some kind of external audit eg Kings Fund Organisational Audit, Yorkshire Peer Review. Several others have been awarded the Investors in People standard.

It is apparent from these various developments that the work of the voluntary hospices is currently being monitored against a variety of different standards in addition to those which derive from the Registered Homes Act 1984. It is also clear that hospices themselves are increasingly seeking external validation of what they do.

3. CURRENT EXPERIENCE OF LOCAL INSPECTION TEAM INSPECTION

The Council’s recent consultation exercise has revealed a number of problems with the present system of regulation and inspection which individual inspectors, no matter how personally competent, cannot overcome. These problems are summarised below;

- There are no nationally agreed criteria for registration. This results in differences in requirements between different authorities.
- There are no standards which are specific to hospice and specialist palliative care.
- There are no requirements for inspectors to have knowledge or training in hospice and specialist palliative care.

- Some nursing home standards are not relevant to hospices.
- The focus of the current system is on buildings, services and facilities rather than on quality of care, the clinical process and outcomes.
- There is minimal user involvement in the monitoring process.

Some individual hospice experiences are given below;

- *We have had examples of Inspection Teams who lacked understanding of palliative care issues.*
- *Our members' experience of inspection varies from a cosy chat to an interrogation, the length of documentation from virtually none to 28 pages with a requirement for "additional information".*
- *It would be helpful if inspectors were made aware of the specific differences in the way hospices work and that some of the nursing home criteria are irrelevant to hospices.*
- *Our inspector agrees that the template is not suitable for use for hospices and supports separate registration.*

4. PRINCIPLES OF HOSPICE REGULATION AND INSPECTION

The Council welcomes the present Select Committee inquiry since, together with the recent White Paper on Modernising Social Services, it presents an opportunity for improving the present arrangements for regulation and inspection of hospices. It suggests that future arrangements should accord with the following principles;

- As independent health care providers, hospices should be subject to regulation in some form irrespective of their funding sources and to reflect good practice.
- Inspection of voluntary hospices should be carried out in the context of nationally identified and agreed minimum standards which are specific to hospice and specialist palliative care.
- Such minimum standards should cover structure, process and outcome but these should not stifle local innovation and agreed service developments.
- Steps should be taken to ensure that such standards were equally applicable to voluntary sector services and NHS services (due allowance being made for differences in corporate status and management).
- There is a spectrum of care across hospice and specialist palliative care services and this range requires recognition.
- Users, patients and families, should be involved in the monitoring process.
- The inspectorate should include inspectors who have been adequately educated about palliative care issues and practice (one option may be to use professionals from within the sector along the lines of the Kings Fund Organisational Audit).

The development of national standards needs to be undertaken in consultation with the sector and utilising the expertise of the sector which can be accessed through the National Hospice Council. In any new system of regulation and inspection it will be important to achieve an appropriate balance between standards which need to be enshrined in legislation, those which can be the subject of DoH circulars and those which are more appropriately defined at regional or local level between commissioners and providers of services.

5. MODERNISING SOCIAL SERVICES

The proposed Commission for Care Standards will have responsibility for regulation and inspection of nursing homes and therefore the regulation and inspection of voluntary hospices could be undertaken by the new Commissions. However it is also possible that hospices may be subject to any arrangements which arise from the consideration referred to in para. 4.44 of the White Paper and which is essentially the subject of the Select Committee inquiry. There is still much debate in the voluntary hospices as to where their regulation and inspection might most appropriately fit ie with nursing homes under the umbrella of the new Commissions or under some other arrangements along with the private hospitals. However, whatever the outcome of that debate, it will be less important than adherence to the principles which should underpin any new arrangements and which are set out in Section 4 above.

6. FUTURE CONSULTATION

The National Council is well placed to assist the development of national minimum standards which are specific to hospice and specialist palliative care services and is ready to do that. Its representatives would be able to provide further detail of that in giving verbal evidence to the Select Committee.

APPENDIX 18

Memorandum by North and East Devon Health Authority (PM 40)

On behalf of North and East Devon Health Authority I would like to submit the following written evidence. I am the nursing homes registration and inspection team manager for the authority and have been in this post for five years. I am a regional representative on the National Nursing Homes Registration and Inspection Advisory Group chaired by Joan Morton.

1. The committee would need to define the types of regulation required when the authority for regulation of nursing homes and mental nursing homes is devolved to the new Commission for Care standards as detailed in the White Paper Modernising Social Services.

- 1.1 See enclosed categories of care paper, currently registered under the Registered Homes Act 1984
- 1.2 Consideration of other areas which may also require regulation might include rehabilitation healthcare, nursing agency care, personal care, acute hospitals for general and mental healthcare, hyperbaric oxygen chambers, & lasers.

2. The committee would need to define the level of regulation

- 2.1 Safety standards
- 2.2 Quality Standards
- 2.3 Consumer Rights issues
- 2.4 Complaints standards
- 2.5 Clinical Governance

3. The committee would need to consider these issues in relation to the difficulty in describing the differences between health and social care. For most of the issues outlined above it would be difficult to describe how the above services could be separated from nursing homes. Therefore to ensure consistency in the regulation this Authority submits that the New Commission for Care Standards should undertake the work.

4. **Example** Certain larger corporate hospital and hospice providers often state they have their own quality departments and audit their own standards. In practice when registration units inspect the standards of care, whilst the units are aware of the requirements, the standards are not always being met. During the last two years we have found inadequate maintenance and safety for a laser, and found inadequacies in infection control in a theatre audit.

5. **Conclusion** This authority believes that the general public have a right to expect certain standards of practice and that these should be regulated by an independent unit.

6. The need for clearly defined Nationally developed standards for inspection in the various field would develop consistency of standards throughout the country.

7. The need to ensure consistency of standards between the new Commissions for Care Standards and other regulators of non-NHS healthcare must be secured. Consideration should also be given to ensure these standards are being met within NHS facilities.

8. In practice the need to develop links and call upon experts from the NHS to support the regulatory process would also need to be secured.

Nursing Homes (Registered Home Act 1984, Section 21)

- 1. General Nursing Care (1) (2) (3) The provision of general nursing care. The Person in Charge of the Home must be of a Registered Nurse* (UKCC Register Parts 1 or 12).
- 2. Specialist Nursing Care (2) (3) The provision of specialist nursing care by reason of for example: Hospice, Brain injury, Physical Disabilities, Rehabilitation, Renal dialysis or to meet the needs beyond those provided in (1) above. The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Part 1 or 12) with additional and appropriate ENB/WNB qualification.
It is likely that Professions Allied to Medicine would be included and that the level of medical care would exceed provision beyond that of core General Medical Services.

Nursing Homes (Registered Home Act 1984, Section 21)

- | | |
|---|---|
| 3. Palliative Nursing Care | Provision of care of the terminally ill that can be carried out in a General Nursing Home. The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Parts 1 or 12). The Person in Charge or the required number of Registered Nurses will have additional and appropriate ENB/WNB qualification. |
| 4. Acute Hospitals (2) (3) | The provision of general, medical, surgical, dental and maternity services in an independent acute hospital or clinic, including day care. The Person in Charge must be a Registered 1st Level Nurse* on the appropriate part of the UKCC Register for the services being provided. |
| 5. Specially Controlled Techniques (2) (3) | The provision of Lasers class 3B or 4, under the charge of an appropriately qualified Medical or Dental Practitioner. |
| 6. Termination of Pregnancy Clinics (2) (3) | Provision of termination of pregnancy under the provisions of the Abortion Act 1967. The Person in Charge of the Home must be of a Registered Nurse (UKCC Register Parts 1.10.12). There is no requirement that the Registered Nurse Part 10 be a "Practising Midwife". |
| 7. Mother and Baby Homes (2) (3) | Provision of care for Mothers and their Babies. The home will be in the charge of a Registered Nurse (UKCC Register Part 1, 10 or 12). |

(The group question the status of this category under the RH Act).

Mental Nursing Homes (Registered Homes Act 1984, Section 22)

- | | |
|---|--|
| 1. Mental Health Nursing Care (2) (3) | Provision of mental health nursing for people with a mental illness (including Alzheimer's Disease, Dementia). The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Parts 3 or 13). |
| 2. Specialised Mental Health Nursing Care (2) (3) | Provision of specialised nursing care for Alcohol, Drug Addiction, Eating Disorders and the care of women with a Mental illness related to childbirth. The Person in Charge of the Home must be a Registered Nurse* (Parts 3 or 13). |
| 3. Mental Health Nursing Care, those detained under the Mental Health Act 1983 (2) (3) | The provision of mental health nursing care for which The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Parts 3 or 13). 24 hour provision on duty of Registered Nurses (UKCC Register Parts 3 or 13) will be required.
The Registration will specify that the home may receive patients who are liable to be detained under the provisions of the Mental Health Act 1983. |
| 4. Learning Disabilities Nursing Care (2) (3) | The provision of nursing care for persons with Learning Disabilities. The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Part 5 or 14). |
| 5. Learning Difficulties Nursing Care for those detained under the Mental Health Act 1983 (2) (3) | The provision of nursing care for patients with learning difficulties. The Person in Charge of the Home must be a Registered Nurse* (UKCC Register Part 5 or 14). 24 hour provision on duty of Registered Nurses* (UKCC Register Parts 5 or 14) will be required. |
| 6. Acute Psychiatric Hospitals (2) (3) | The provision of mental health care in an independent Acute Psychiatric hospital or clinic, including the provision of day care. The Person in Charge must be a Registered 1st Level Nurse* on the appropriate part of the UKCC Register for the services being provided. |

Reference numbers (x)

1. May include provision for elderly people with a degree of mental disability, who are able to live harmoniously with people without such a disability, and whose mental health needs can be appropriately met in that setting.

2. Age specific or age range to be stated as agreed between applicant and the registering authority.

3. Age definition is made with reference to the Children's Act 1989, and in consideration of the "Alitt enquiry" and the subsequent Clothier report, the requirement to have RSCN staff on duty or available must also be considered.

4. The primary qualification given in the categories relates to the Person in Charge of the home, the skill mix of staff beyond this is a matter for consideration by Health Authorities when forming the "Staffing Notice".

NOTES:

The definitions developed are based on patients nursing care needs and in consideration of the medical diagnosis.

The age range is a matter for the registering authority to determine with the applicant for registration, having due regard to the physical, social and psychological needs of the planned patient/client group.

The "definitions" allow for the same definition being used in various settings given the age and other indicators are used to give specific category details.

The distinction between organic and functional disorder is not made, the decision as to the level of, and the degree of disability in those with mental health problems would be an important factor in helping people responsible for carrying out assessments to decide whether a General Nursing Home or a Mental Nursing Home is appropriate.

The need for multi-disciplinary assessments is vital if the needs of patients are to be clearly identified and met.

The services of the Community Health and Mental Health Nursing Teams should be engaged as appropriate to provide advice and support in the management of patients care when the skills within the Nursing Home need to be supplemented. These include Community Nurses, and Nurse Specialists eg: Tissue Viability, Continence Promotion, Infection Control and Diabetes Nurses.

*The Registered Homes Act 1984 clearly states that a Nursing Home can be in the charge of either a registered medical practitioner or a qualified nurse or in the case of a maternity home, a registered midwife.

APPENDIX 19

Memorandum by Counsel and Care for the Elderly (PM 42)

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE

INTRODUCTION

In response to the press notice announcing the Committee's new inquiry, and following clarification from an official, we would like to make a number of comments on the adequacy of the complaints procedures relating to such provision.

The publication of the White Paper, *Modernising Social Services*, on 30 November, addresses many of the concerns we would have made about regulation, monitoring and inspection, but it does leave us with concerns about the consistency and adequacy of the ways in which complaints are dealt with by a burgeoning independent sector.

THE HEALTHCARE OF OLDER PEOPLE

NHS trusts now provide for only a small proportion of the older people in need of continuing healthcare. Less than 40,000 older people are now cared for within NHS settings, and this figure is continuing to fall, while more than 200,000 people are living in nursing homes, largely provided by private sector organisations.

These older people are reliant on the provider organisation for their continuing care—both personal and health related—or for effective arrangements being made on their behalf with other practitioners. In most cases things work very well with dedicated and skilful managers and staff acting in the best interests of those whom they are looking after. However, when things go wrong, or the patient or resident or their family feel dissatisfied there is scope for confusion or a less good response than would be expected from a public sector provision subject to Regulations published by the Secretary of State for Health.

COMPLAINTS PROCEDURES

The current NHS complaints system is now in its third year of operation, and has been implemented with varying degrees of success around the country.

Complaints procedures relating to the provision of community care services have been operational since the full implementation of the NHS and Community Care Act in 1993. As with the NHS procedures there has been variable success, as judged by the comments of complainants and government inspectors.

The Registered Homes Act 1984 requires every registered home, whether providing for health and social care and regardless of the client group served, to have a complaints procedure, and to ensure that residents are informed about it. In line with the approach adopted for health and local authorities there is an expectation that complaints ought to be dealt with at source, that is to say within the home by its manager, without recourse to the registration authority.

OUR EXPERIENCE ADVISING OLDER PEOPLE AND THEIR FAMILIES

People contact our advice service by telephone and letter from all over the country for a wide range of reasons. Sometimes they simply need some information, while others need advice to enable them to make use of the information. A smaller group need a member of staff to advocate for them or to put them in touch with an organisation in their locality to act as their advocate.

While we have become involved in advocating across a wide range of issues, especially problems associated with the provision of community care services and the responsibilities of health and social services (as highlighted by the Committee's recently published inquiry) a recurrent theme is the management and resolution of complaints.

A complaint made by a person resident in a nursing care home ought to be dealt with by the management of that home, but that is not always possible. Sometimes this arises from the complainant's fears about how they will be dealt with by managers and staff subsequent to complaining, leading to the decision not to make a complaint. On other occasions the home's owner or manager may be ill prepared or unprepared to deal with the matter effectively, or at all. Complainants may become labelled as whingers, difficult to please, who get some pleasure from making a fuss, rather than as consumers of a service deserving respect and a reasoned response to their legitimate concerns. In any of these examples the resident (or more likely family or friends acting on their behalf) has to identify another way forward to progress discussion of their concerns. If they approach us or other advice givers they will be given information to assist them in making their way through the care maze. Those whose care has been arranged by the local authority may well approach the care manager who made the original assessment and arranged the placement—a logical and some might say obvious step to take, particularly so if they were happy with the way in which the care manager handled their dealings with resident and family at an earlier time of some distress and anxiety. But the local authority has no powers relating to the conduct and management of nursing homes, though it could choose to exercise its power as a purchaser by deciding not to purchase any further care at the establishment or by invoking the contract terms to remove the resident. The regulation of nursing homes is a matter for the local health authority, a body with which the resident and family may have had no prior contact, and which may prove difficult to locate without information on where to look. If the home is one of the minority of homes which publishes a brochure it may contain the name, address and telephone number of the designated inspector with responsibility for the home.

By this stage the complainant, perhaps already distressed, becomes confused too—the distinction between nursing care and residential care and the regulators of these two sectors may be clear to administrators, but is neither clear nor logical to those who use the services. Again this is borne out by the Committee's report on the health and social care divide.

Throughout the past decade, as the shape of social and health care has been changing, the independent sector has been most united and vociferous in calling for a "level playing field". In doing so they have been highlighting inconsistencies in the requirements put on them by inspectors, or the levels of funding for places purchased by local authorities as distinct from the cost of continuing to provide their own directly managed care homes. There is a case for extending the independent sector's call so that all providers of nursing care and residential care should have complaints procedures in place that mirror those relating to public sector provision. This allows for an informal and local approach to resolving a dispute. If this is exhausted without satisfaction then a formal investigation ensues, and if this fails to bring the situation to an acceptable end then the complainant may seek a review which introduces an independent person into the process. Many complainants are more prepared to accept what may have hitherto been unacceptable at the point when a degree of independence has been introduced to the process.

CONCLUSION

Complaining is frequently a difficult task and as a consequence people may accept poor standards of care or even mistreatment. Setting out clearer more consistent routes that bring equity to consumers, regardless of where they are receiving their healthcare, is a change worthy of consideration and could be implemented by changes to the existing Regulations governing the management of nursing homes.

APPENDIX 20

Memorandum by The Society of Chiropodists and Podiatrists (PM 43)

CONTENTS

1. Executive Summary
2. The Society of Chiropodists and Podiatrists
3. Professional/Regulatory structures applying to the State Registered Sector
 - Qualifications required for State Registration
 - Continuing Professional Development
 - The Code of Ethics
 - Public Complaints procedure for patients receiving treatment in the private sector
4. Professional/Regulatory Procedures applying to the non State Registered Sector
 - Scale and Structures of the non State Registered sector
 - Consequent Self Regulatory Regimes relating to the non State Registered Sector
5. Problems posed to the public by different professional and regulatory regimes
6. Addendum

SECTION 1

EXECUTIVE SUMMARY

Most consumers are unaware that there is no protection of the titles chiropodist or podiatrist and that as a consequence there is no common minimum standard of qualification or regulation for any individual using these titles.

This situation brings about considerable market distortion and leads to patients differentiating between individual chiropody services on the basis of such issues as price, while failing to appreciate the widely varying level of qualification and regulation which may apply to individual practitioners.

A clear and transparent regulatory framework for private chiropody and podiatry services can only be achieved if there are common levels of training and professional standards among those using the professional titles. In particular the Society believes that the essential legislative and regulatory pre-requisites for an efficient system of regulation are:

- Statutory protection for the titles *chiropodist* and *podiatrist*.
- The setting of minimum educational and training standards for those using the titles chiropodist and podiatrist, in line with the qualifications currently required for State Registration, and validated by the Joint Quality Assurance Committee.
- The establishment of transitional arrangements, to permit non-State Registered chiropodists and podiatrists to train to the prescribed minimum professional standard.

Once these pre-requisites are in place, a statutory system of regulation should be introduced for the chiropody and podiatry professions. This regulatory regime should contain the following key elements:

- Professional regulation should be overseen by the Chiropodists' Board of the Council for the Professions Supplementary to Medicine.
- The Board should have powers to adjudicate and introduce sanctions in a range of issue areas relating to professional conduct and activity, not just in most heinous issues, as is currently the case in their regulation of State Registration.
- The Board should have the power to approve the quality of training structures and standards to ensure necessary competence to practise.
- Issues falling outside areas of statutory regulation, such as those relating to professional fees and charges, should remain within the domain of professional organisations, such as the Society of Chiropodists and Podiatrists and their self-regulatory structures.
- The Board should require evidence of Continuing Professional Development (CPD) for continued professional registration. Professional bodies should facilitate CPD.

SECTION 2

THE SOCIETY OF CHIROPODISTS AND PODIATRISTS

The Society of Chiropodists and Podiatrists is the largest professional body representing State Registered Chiropodists and Podiatrists in the UK. It is also a Trade Union on the Special Register. Established in 1912, the Society's membership stands at 7,300, which represents approximately 92 per cent of the State Register. In addition, the Society's Students' Association has 1,200 members.

The Society recently merged with two smaller organisations, representing Chiropody and Podiatry Managers and Podiatric Surgeons and can now speak for all specialist interests within the profession.

The Society includes among its core objectives the promotion of an efficient and effective footcare regime in the UK.

Mobility and independence are essential to the quality of life. Many people of all ages have their mobility restricted by chronic foot pain. In particular the elderly, and those who suffer from diseases such as diabetes, rheumatoid arthritis and poor circulation may develop specific problems with their feet and are among those for whom chiropody/podiatry is a vital service.

State Registered Chiropody/Podiatry is a profession allied to medicine (PAM) and is regulated by the 1960 Professions Supplementary to Medicine Act. The regulatory body responsible for registering chiropodists is the Chiropodists' Board of the Council for Professions Supplementary to Medicine. This is a statutory body under the auspices of the Privy Council. Its maintenance and administration is financed by the registrants' annual retention fees. It is entirely self-regulatory and remains independent of political influence.

Society members are subject to a Code of Professional Conduct, and to the standards of clinical practice laid down by the Council of the Society.

State Registered Chiropodists may work in private practice, industrial appointments or the public sector. By statute, only State Registered Chiropodists may be employed within the NHS or Local Authority setting.

State Registered Chiropodists are qualified to provide treatment for foot pathology and in the training schools they gain experience in treating a wide range of conditions. All students now learn to perform a range of local anaesthetic techniques, and all perform nail surgery during their undergraduate courses.

Having trained as generalists, therefore once qualified and registered many specialise in, for example, diabetology, biomechanics, orthoses, sports medicine, rheumatology, tissue viability, podopaediatrics and nowadays an increasing number of podiatrists have undergone extensive post-graduate training in bone surgery.

Within the private sector, practitioners offer the full range of treatments to their patients, whilst often specialising in more comprehensive treatment of a particular speciality. Fee structures vary between practitioners and between procedures, and patients are advised in advance of the probable cost of a course of treatment.

Many practices comprise several practitioners working, jointly, as this decreases overheads and increases available facilities. Some private practitioners will also employ chiropody assistants.

SECTION 3

PROFESSIONAL/REGULATORY STRUCTURES APPLYING TO THE STATE REGISTERED SECTOR

(1) *Qualifications required for State Registration*

In order to be able to register with the Council for Professions Supplementary Medicine (CPSM) nowadays, one must have undergone a three or four year honours degree programme, leading to a BSc in Podiatric medicine, at one of the 14 schools of Podiatric Medicine. Such schools are now placed within universities, and many students undertake at least part of their study programme with students from other disciplines.

The courses must be validated for the purposes of State Registration by the Joint Quality Assurance Committee (JQAC), which comprises representatives from the Chiropodists' Board and the Society. This Committee carries out regular (approximately every three–five years) external inspections of each school of podiatric medicine, and thus ensures adherence to the Core Curriculum laid down by JQAC.

The course is a combination of theoretical teaching and practical clinical learning. The minimum requirement for the practical component is 1,000 hours, with practical teaching taking place within the schools and on placements within the NHS.

The Society approves the Chief Examiner, who has jurisdiction over the entire course, and it approves external examiners, who act in an advisory capacity during examinations and must produce written reports on standards attained to the JQAC.

In this way the courses are overseen to ensure their acceptability for the purposes of State Registration.

Once a student has graduated, they then apply to the Chiropodists' Board of the CPSM for statutory registration. This registration must be renewed annually.

The remit of the Chiropodists' Board is to ensure that all registrants abide by the Statement of Conduct (and to bring them to task via the Disciplinary Committee if they do not), to validate undergraduate courses, and to act as the Designated Authority for the regulation of entry to State Registration from European and Overseas Countries. (EC is covered by the first Directive of Mutual Recognition).

Registration with the Chiropodists' Board entitles the State Registered Chiropodist to procure and administer certain Prescription Only Medicines (POMs) such as local analgesics, oral analgesics and anti-fungal agents.

(2) Continuing Professional Development (CPD)

State Registered Chiropodists are encouraged to undertake lifelong learning, in order to remain effective practitioners. There is at present no statutory obligation on them to do so under the terms of the 1960 Act, but it is hoped that any new Act would reflect the need for CPD. The Society has recommended the development of a clause such as; "A person's registration may be renewed subject to such conditions of CPD that would ensure and enhance safe and effective practice". The Society has for several years made strong recommendations for such a clause to be included.

However, a significant number of members have undertaken post-graduate training and qualifications, such as further education degrees, diabetic courses, podiatric surgery, rheumatology, sports medicine. Over the years, some of these courses have been included in the undergraduate degree programme and the post-graduate courses have thus become increasingly and accordingly more advanced.

In addition, there are now a significant number of State Registered Chiropodists who have undertaken MSc's, MPhil's and PhD's.

The Society continues to encourage all of its members to take part in CPD and at present is in the process of producing a wide-ranging, accessible and equitable programme of CPD. The Society's updated "Minimum Standards of Clinical Practice" reflect the thinking on CPD.

The Society considers one of the roles of a professional body is to co-ordinate CPD for its members, and would welcome a strengthening of that role via statute.

(3) The Code of Ethics

The Society's Code of Professional Conduct (see attached) lays down specific standards by which society members expect to be judged. Breaches of these standards are regularly considered by the Committee of Professional Conduct and members are, if necessary, brought to task. In extreme cases they may be removed from membership.

In addition, the Statement of Conduct of the Chiropodists' Board of the CPSM is marshalled by the Disciplinary Committee of the Board and wayward registrants are removed from the register.

It is worth stating that, at present, removal from the register is no bar to practice in the private sector, and an individual who has been "struck off" for a variety of offences (including those of offences against children) may continue to practice freely, using the title *chiropodist*, or *podiatrist* in the private sector.

(4) Public Complaints Procedure for Patients receiving treatment in the Private Sector

The switch from diplomas to degrees during the 1980s provided the public with a standard which is understood by the majority of people. The public expects a certain level of education from a degree, and they expect any profession to regulate itself.

Because the Society is visible and known to the public via our web-site, our foot health leaflets and highly targeted advertising, the public complain to the Society when they consider that the service they have received has fallen short of that which they would expect.

However, the public is largely unaware of the differing qualifications and standards available and tend to complain to the Society on issues relating to non-State Registered Chiropodists, as well as issues relating to Society members. The Society is naturally not in any position to do anything about the behaviour of anyone who is not a member. Our own members are brought before the Professional Conduct Committee, either in writing or in person if need be, to answer complaints received by the Society.

A number of the cases annually concern the cost of treatment, and most are resolved amicably, in correspondence between the Society and the complainant. The complainant can, of course, approach either the Society, or the Chiropodists' Board direct or both. There is an agreement between the Society and the Board that if both receive the same complaint, the Board will hear it first and then the Society will consider it in the light of the Board's findings.

At present, to be removed from the State Register, a registrant must be found guilty of infamous conduct and the Society would welcome the broadening of the Board's remit in order that it might adjudicate on lesser charges, as well as the most heinous.

The Society lays down the Minimum Standards of Clinical Practice for its members, with accompanying appropriate advice, including statutory legislative duties. In addition we publish guidance on specific conditions and the treatment acceptable. The Public Relations Committee publishes leaflets on foot health to the public.

All Society members are covered by a professional indemnity insurance scheme which is administered by the Society and covers each member for £2m.

SECTION 4

PROFESSIONAL/REGULATORY PROCEDURES APPLYING TO THE NON-STATE REGISTERED SECTOR

(1) *Scale and Structures of the Non-State Registered Sector*

The non-State Registered sector exists entirely in the private sector, since this is not covered by statute.

There are several private institutions which charge applicants to train as chiropodists, for varying lengths of time. The largest of these is the SMAE Institute, in Berkshire.

We are informed that the SMAE course is divided into 15 modules of theoretical learning, which may be undertaken as distance learning exercise, marked centrally, or which may be undertaken during a nine month residential course. In both cases, the modules are completed within one year, with a recommended study period of 12 hours per module.

The practical component of the course may be completed as a 10 day residential course, or by means of three months in a clinic, if taken as completion of the nine month residential course.

The hours thus devoted to clinical practice and learning are variable and even by recommendation from the school cannot exceed 360 hours. At the end of the course there is a written examination.

In addition to the SMAE course, Scholl have offered training courses for chiropodists, which do not lead to State registration. So have the Elite School of Chiropody, the Firestone School in Glasgow and a few others.

Little is known of the courses run by these schools, but it is believed that the throughput of students is very small. At one time the Institute of Chiropodists and Podiatrists (see below) ran its own training for non-State Registered Chiropodists. No course offered by any of the independent schools is recognised for the purposes of State Registration and the chiropodists thus trained are not eligible for employment in the NHS or local authorities.

(2) *Consequent Self-Regulatory Regimes relating to the non-State Registered Sector*

Non-State Registered Chiropodists work entirely in the private sector, where they offer treatments in their own premises, or as domiciliary visits. They also attend some residential homes. Since they are not entitled to access to POMs, their treatments deal only with those conditions and procedures which do not require local anaesthetic techniques.

Chiropodists who qualify via these routes often become members of the Institute of Chiropodists and Podiatrists. We are told that this body has a membership of approximately 2,000, but as the Institute admits both State Registered and non-State Registered into membership, not all of these 2,000 are non-State Registered. There are some other smaller organisations which the non-State Registered may join, such as The English Chiropody Association which is reputed to have 200 members. There is also the British Chiropodists' Association.

Regulation of practice and conduct of the non-State Registered sector is therefore carried out by the Institute (or another organisation) and via the indemnity insurance that many hold through the SMAE Institute.

Details of any proceedings against members of these organisations are not possible to obtain, since such proceedings are not in the public domain.

Discussion from time to time with the professional bodies representing the non-State Registered sector, particularly discussions held on amending legislation, indicate that they would wish to be part of any amended regulatory mechanism and would welcome a transparent system for the public good.

SECTION 5

PROBLEMS POSED TO THE PUBLIC BY DIFFERENT PROFESSIONAL AND REGULATORY REGIMES

The public is unaware of the different training regimes available. They assume that anyone who calls themselves a chiropodist or podiatrist is trained to the same level. Examination of any Yellow Pages section on chiropodist highlights this problem and confusion, in that the number of designatory letters used is myriad. The public assumes that anyone using letters after their name is trained to a consistent level.

The public is further confused and remains mostly unaware, that chiropodists and podiatrists are not protected titles, and that, in fact, one does not need any training at all to call oneself by those titles. Further confusion is caused by the growing awareness amongst NHS patients that a chiropodist/podiatrist must be State Registered to work for the NHS.

With these points in mind, it is easy to see how the public further assumes that the profession is fully-regulated and that poor practice will be dealt with by an official body. They are therefore not aware that they may well be consulting a chiropodist who has been removed either from the State register or from Society membership for falling short of the standards of excellence required, and which they have the right to expect.

Annual renewal of registration at present places a duty on the registrant to notify the Registrar of any annual offences they may have been found guilty of. Outside the State Registration system, we are not aware of any such duty.

The difficulties outlined this far may well discourage members of the public from complaining about poor practice, since they cannot discover to whom to complain. The Society and CPSM structures are in the public domain and are therefore accessible.

We believe that the Institute of Chiropodists and Podiatrists, and the SMAE Institute and others have ethical codes, but we do not know the content of, or mechanisms surrounding, these.

Since much of the regulatory mechanism for those practitioners not regulated by the State Register is not transparent, the public finds itself ensnared in difficulties when it needs to bring poor practice to the notice of the appropriate body.

SECTION 6: ADDENDUM

GOVERNMENT INITIATIVE

The Government has recently indicated that it believes that the 1960 Professions Supplementary to Medicine Act, which provides the legislative framework for all PAMs, including chiropody, is outdated and in need of reform.

Currently, neither the mechanisms by which the government intends to bring about this reform, nor the precise measures that will replace the 1960 Act have been made clear. However, we understand that the department of Health is of the opinion that it is unlikely that there will be sufficient time to introduce new primary legislation in this area during the lifetime of this Parliament and possibly the next. For this reason, the Department is proposing to use primary legislation solely in order to grant the Secretary of State for Health the power to amend primary legislation by order. In the case of the PSM Act, the Department proposes that the Secretary of State would have the power to repeal and replace the PSM Act.

It is possible that one of the measures introduced to replace the PSM Act may cover statutory protection of PAM titles and possibly also a new over-arching regulatory body for all PAMs.

While the Society views any move towards the statutory protection of the titles *chiropodist* and *podiatrist* as positive, the lack of clarity in the Government's proposals leads to some concerns on the part of the Society. In particular, before endorsing the Government's proposals, the Society would like further information and clarification on the Governments intentions with regard to:

- The precise powers that would be passed to the Secretary of State by means of primary legislation.
- The regulatory structures to be introduced by way of secondary legislation.
- The motivation for the Government's decision to move away for regulatory purposes from single professional boards, such as the Chiropodists Board, of the Council for the Professions Supplementary to Medicine, to a single regulatory body for all PAMs.
- The checks and controls on the Secretary of State's power that will be set in place to ensure a secure and stable regulatory regime.

APPENDIX 21

Memorandum by Sinclair Montrose Healthcare PLC (PM 45)

INTRODUCTION

Sinclair Montrose Healthcare was founded in 1996, bringing two healthcare companies—Match Healthcare Services (a staffing company) and GP Deputising Services together under one umbrella. The company was floated on AIM in June 1996 and funds raised for the roll out of Medicentre—a private GP service based in retail locations, the first branch network GP service in the UK.

There are currently 12 Medicentres as follows:

- Victoria railway station—two Medicentres.
- Euston railway station.
- Waterloo railway station.
- Oxford Street Plaza shopping centre.
- The City, London.
- Metro Centre shopping centre—Gateshead.
- Merryhill shopping centre—Dudley.
- Solihull—attached to Sainsbury's.
- Sheffield—attached to Sainsbury's.
- Birmingham—in store in Boots.
- Kingston—in store in Boots.

The company whilst rolling out Medicentre has developed computer systems, quality procedures and monitoring and audit programmes in line with our policy of ISO 9002 accreditation in all divisions of the company. These are described in more detail in this submission. Medicentre is, we believe, at the forefront of developing auditable standards in the delivery of its primary healthcare services.

AIM OF MEDICENTRE AND COMMITMENT TO QUALITY

The mission statement for Medicentre (appendix one) is:

"Convenient, accessible and professional health services for our clients"

Our quality policy states the following:

"In order to ensure that all work is carried out in a manner that will provide the highest quality of service to clients, Medicentre has implemented a quality system in line with the requirements of ISO 9002"

Quality concerns everyone. All staff have a responsibility:

- To strive to exceed the requirements of our clients.
- To be completely familiar with and understand all procedures relevant to their work with the company.
- To follow and comply with the requirements of all such procedures.

Medicentre was accredited with the quality standard in February 1999. We believe that it is the first primary healthcare service in the UK to have achieved this standard. The detailed quality standards are shown at Appendix 2. Phase two of our quality system, which is currently being implemented, will incorporate all clinical procedures carried out and will be audited by medical and nursing staff. It is anticipated that phase two will be fully implemented and accredited by the end of 1999.¹

INFORMATION AND COMMUNICATION

Detailed medical histories are taken from all new clients who visit a Medicentre. It is sometimes necessary to gain further information from the client's NHS GP (if they have one) prior to treatment. On the initial registration form the client will indicate whether we can write to their NHS GP with details of the consultation which we will automatically do unless indicated otherwise by the client. Inevitably there are a small number of clients who we cannot treat without consulting their previous GP or their current GP. Many clients now use Medicentre as their only GP service.

The treatment of patients without access to their medical records is common and accepted practice in the NHS with the development of GP co-operatives, and the many primary healthcare cases which present at Accident and Emergency. We estimate that these may be as high as 15 million consultations per annum.

¹The quality system and procedures at Appendix 2 reflect a substantial investment and these documents are therefore commercially sensitive. We would wish these documents to remain confidential to the committee.

Medicentre enters the full past medical history of all clients on to our proprietary computer system. The system works on a secure wide area network which allows all clients seen at a Medicentre to use any of our sites, and their medical records are immediately available to the GP. Access to medical information is restricted to our General Practitioners and nurses. Interfaces with NHS GP systems are possible, and as the Medicentre network grows we would envisage that more GPs will wish to link in with our quality and computer systems.

PRESS COMMENT

Health Which? reported one of the Medicentre GPs to the General Medical Council (GMC) for alleged professional negligence. The GMC have found that there is no case to answer and have dismissed the complaint. Despite this, Health Which? have refused to print a retraction. Health Which? made a number of allegations in their article of April 1998. Despite repeatedly requesting that Health Which? supply Medicentre with details of these allegations they have continued to refuse to do so, therefore stopping our ability to investigate their "complaints" or to allow Medicentre a fair right to respond. The allegations made by Health Which? have been repeated, or referred to in most of the national press and trade press on numerous occasions. We believe that it is grossly unfair that Medicentre has had no ability to respond to their article and fail to understand why if there is any substance to their complaints that they are unwilling to allow these to be channelled through our complaints procedure. The fact that the GMC has dismissed their most "serious" complaint would indicate that there is no substance whatsoever to their mischievous and damaging article. Full details of all the correspondence are available for the committee if requested.

SUMMARY AND CONCLUSION

Since the development of Medicentre, considerable investment has been made in the development of quality systems, information technology, communication systems, and audit procedures. Accreditation for the first stage of this work was completed by the beginning of February 1999, and the more complicated second stage, which involves the development and implementation of clinical standards, will be complete by the end of this year. We believe that this puts Medicentre at the forefront of providing standardised high quality primary healthcare services in the UK. We envisage that similar standards will, and should, be applicable to all primary healthcare services whether these are public or private. We believe that everyone in the UK is entitled to high quality services delivered to a consistent standard at all times, whether during the day, or out of normal practice hours.

January 1999

APPENDIX 22

Memorandum by the King's Fund (PM 47)

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE

The King's Fund is an independent charity which aims to improve the health and healthcare of Londoners. We undertake health policy research and analysis, promote good practice in health and social care, support leadership development and offer grants to London projects. King's Fund staff work in organisations throughout the UK and abroad to learn from others and to disseminate best practice in health and social care.

SUMMARY OF ARGUMENTS

1. This memorandum is submitted as evidence to the inquiry into the regulation of private and other independent healthcare. There are a number of issues that require action, and the Committee can perform a useful service in bringing these issues to the government's attention.
2. Our arguments are based principally on two observations. Firstly, we observe that there is a patchwork of regulation of independent healthcare. Current arrangements in the independent sector mean that some people will have access to complaints procedures if things go wrong, whereas others receiving the same treatment do not. If, for example, people pay for their own hospital treatment, they may have no recourse to complaints procedures if they cannot resolve problems with the hospital itself. Their only options may be to use the legal system or approach the General Medical Council, which are only appropriate if the problems are very serious. This contrasts with the recourse available to those who are insured, or who use NHS services.
3. Secondly, the NHS and independent sectors are already intimately related, and the boundary between them is blurred. NHS consultants can practice privately, NHS patients are routinely treated in private settings, and pay beds are islands of private practice within the NHS. Policies such as the Private Finance Initiative are making public-private relations in healthcare more complex still. These examples are not trivial:

almost 20 per cent of healthcare is independently supplied or privately funded¹, and the projected value of PFI hospital contracts is already well over £1 billion. It is therefore sensible to think of our healthcare system as being a mixed economy, albeit with a dominant state funded service at its heart.

4. A focus on independent healthcare is therefore appropriate and timely: but we think that the issues are best addressed in the context of the regulation of the financing and delivery of care in all settings, and by paying close attention to the complex relationships between the NHS and independent sectors². In addition, the boundary between both purchasing and providing health and social care is increasingly mobile, so there should be an integrated approach to the regulation of the financing and provision of healthcare. We believe that the principal objectives of a revised regulatory regime should be to limit the effects of private payment on generating inequalities in access to care, and to provide the same assurances concerning the quality of clinical care and recourse to complaints procedures for treatment, wherever people are treated.

5. Progress towards these objectives will require action in a number of areas. The following sections review, in turn, the regulation of individual professionals, of organisations that provide healthcare, the financing of healthcare and the arrangements for redress. The final section comments on the government's proposals for the regulation of social care, which we think holds potential lessons for the regulation of healthcare.

REGULATING THE INDIVIDUAL PROFESSIONAL

6. There are two reasons for recommending increased regulation of the individual clinical professional in independent or private healthcare. The first is that NHS patients who are treated in the private setting may not be able to rely on the same system of quality assurance and accountability that underpins care in NHS settings. This inconsistency is inequitable and unfair. The second reason is that patients regardless of whether they are treated in the private or public sectors should expect to receive a similarly assured high quality of care. However, the independent and private sectors are not under the same requirement to ensure that individual professionals whom they employ or contract with are part of a system of professional or organisational regulation and quality assurance.

7. Within the independent and public sectors healthcare is increasingly being provided by the co-ordinated efforts of many different organisations working together. This care is often provided in new settings other than the GP surgery or hospital consultation room. This means that regulatory frameworks that are specific to particular institutions or care settings may become irrelevant to the provision of many healthcare services. The best way to ensure that there is an assurance of quality is to focus on the systems for professional self-regulation of the individual clinical professional regardless of the organisational context or care setting. The government has already called for the modernisation of professional self-regulation in healthcare and we await the results of much self-examination by the professional bodies concerned. However, there are particular issues that need to be addressed when considering how mechanisms of self-regulation impact upon the provision of private and independent healthcare.

8. We wish to highlight three areas of concern. Firstly, clarity over the contractual arrangements that allow individual professionals to work for both the public and private sectors. Secondly, the need for consistency in professional mechanisms for registering different healthcare professions and assuring standards of professional competence. Thirdly, extending the obligation for clinical professionals to participate in the proposed national audit and re-validation systems that are being put in place for the NHS, to those working in the private or independent sector. We will address these issues in turn.

9. We acknowledge that there have been efforts to establish greater clarity in the NHS consultant contract. However, it is still not possible to access information about the extent of private working, or the number of work hours expected for the NHS and the latitude for private or independent sector activity. It isn't possible to identify reliable information from which to assess the impact of clinical professionals working for both the public and private sectors on either quantity or quality of care. We recommend that standard information is required for all consultants on respective hours and workload conducted in both sectors.

10. On the issue of self-regulation there are two basic problems. The first is that some healthcare workers do not have a professional body to provide professional accountability, registration and self-regulation. These workers are able to work in the private and independent sector without any mechanism for assuring their professional standing. The second problem is that private and independent organisation may employ healthcare staff without professional registration thus denying patients the assurance of professional standing that such registration represents.

11. We recommend that healthcare workers without professional representation and associated systems of self-regulation are strongly encouraged to develop such systems or be incorporated into already existing ones. These systems should register appropriately competent workers. Registration should represent a protection of title for those healthcare workers. Self-regulation should meet basic criteria for assuring professional competence and include open systems for the fair investigation of any perception of poor

¹ Laing and Buisson, Annual Review of Healthcare 1998. This figure includes all independent hospital and residential/nursing home care.

² In principle it is possible to interpret the terms of reference to include complementary medicine, over-the-counter medicines, and a number of other topics. The Committee may feel there is merit in considering these issues as part of its inquiry, but for reasons of brevity these wider issues are not discussed in this memorandum.

performance. If professional performance is found to be below standard and doesn't improve with education and re-training then there should be mechanisms for suspending registration and professional title.

12. We recommend that the government intervene to limit either the use of professional titles or the particular services or roles than can be performed by those who are not part of an appropriate system of self-regulation. Given the number of different and emerging professions providing healthcare services we believe that the idea of an overarching body with responsibility for developing professional self-regulation across healthcare merits attention. Such a body would be charged with ensuring consistency in the way that self-regulation is applied across different healthcare professions.

13. Recent proposals for assuring quality in the NHS have included placing obligations upon doctors and other healthcare professionals to participate in comparative national audits of performance co-ordinated by appropriate professional bodies. Similarly, the professional regulatory bodies are also looking at mechanisms for re-validating the professional competence of registered professionals. It is currently uncertain what sanctions will be proposed to counter any reluctance to participate but it may be that employment or registration could be rescinded. We recommend that the obligation to participate with these systems of national audit be extended to the work that healthcare professionals undertake in the private or independent sector.

REGULATING THE HEALTHCARE ORGANISATION

14. We believe that as well as assuring quality through effective mechanisms for professional self-regulation a responsibility for quality of care also arises at the level of the healthcare organisation employing healthcare professionals and providing health services.

15. We recommend that the same conditions that apply to NHS organisations concerning their employment of healthcare professions be applied to private and independent healthcare organisations. This would mean that only healthcare workers registered with an appropriate self-regulatory professional body could be employed. Where the individual provider of healthcare is not using professionally recognised skills or the area of healthcare is still emerging and doesn't yet have a body for effective self-regulation then the person in charge of the service must be part of a mechanism for professional accountability.

16. Similarly, we recommend that the obligation currently being placed on NHS organisations to introduce systems of clinical governance and participate in associated systems of inspection be extended to the private and independent sectors. This system must enable the organisation to identify and effectively manage poor or dangerous clinical performance through compulsory and evidence-based audit and peer review. It must also include systems to review and change clinical behaviour in line with the latest research evidence for effective and appropriate practice.

17. Given that NHS patients may be treated in private settings it is important that at the very least NHS patients should have the same level of protection wherever they are treated. Therefore we recommend that the proposed Commission for Health Improvement (CHI) should have a remit that includes the inspection of the independent sector to ensure that they have such quality assurance mechanisms in place. The Commission should be obliged to publish its reports on the systems for quality assurance within the independent as well as the public sector so that this information can be used by the public. The state should also reserve the right to act to close or suspend the working of any independent institution that fails to meet basic benchmarks during this CHI inspection. Clearly this would have financial consequences which we would expect the independent sector to meet.

FINANCIAL REGULATION

18. Almost six-and-a-half million people are covered by private medical insurance, and this is the main source of financing of privately provided treatment. We are entering a period of product innovation, with some insurers offering cover for primary healthcare and dental care, apparently in competition with health cash plans. Some six million people currently have health cash plans (HSA Healthcare alone has three million members), which provide payments when people use dental, optical and other health services. These services may be provided privately, by NHS services which are charged for, or may be services provided by the NHS. And, increasing number of people now pay for their own treatment: there has been a steady rise in self-payment, and some 10 per cent of private in-patient procedures are paid for by individuals from their own pockets.³

19. The main focus of financial regulation in the independent healthcare sector is on insurance and other financial instruments. There is external regulation of the ability of insurance firms to conduct business by the Insurance Directorate, and of many health cash providers by the Friendly Societies Commission and the Association of Friendly Societies: all three are now part of the Financial Services Authority (FSA). The selling of private medical insurance products is subject to self-regulation, embodied in Codes of Conduct developed by the Association of British Insurers. Firms selling private medical insurance have internal complaints procedures, and if complaints can not be resolved locally then cases can be referred to an external body: most

³ Laing and Buisson, Annual Review of Healthcare 1998.

firms belong to either the Personal Insurance Arbitration Service or the Insurance Ombudsman Bureau schemes. However, not all organisations that sell health cash plans are members of complaints schemes. We recommend that all financing organisations are required to join appropriate complaints schemes.

20. We note the proposal that the FSA should extend its powers to non-life insurance, including private medical insurance, and the possibility that the personal investment, insurance and banking ombudsman schemes will be merged. These may well provide more satisfactory redress for consumers. The recent Office of Fair Trading report on private medical insurance and other health-related products, similarly, seems likely to lead to changes which will provide greater protection for consumers.

21. These developments are welcome, but we think that two specific points merit the Committee's attention. There will still be gaps in regulation in the private healthcare sector, and regulation may be concerned principally with the processes of underwriting and selling products, and not with their appropriateness *per se*.

22. We recommend that all methods of payment should be included in a review of the financing of private healthcare. It is important to recognise the variety of means already used to pay for healthcare privately, and the anomalies this creates. The most obvious gap at present is for people who pay for their treatment out of their own pockets. If they experience problems they have few options if they cannot resolve problems with their consultant or hospital: they can only use the legal system or approach the GMC, but these are only appropriate in the most serious cases. People who have health cash plans are also poorly protected, since regulation focuses on the financial status of the organisations which offer them. We think it is necessary to devise regulations on the basis that there will be a number of different sources of financing of private healthcare in the future, and so the different types of financing should be considered in the round.

23. We recommend that reform of regulation should include the powers to examine the appropriateness of products. We can see a situation emerging where the process of selling is well regulated, but people still buy inappropriate products, because they lack information about their value for money. The government and the FSA should therefore be encouraged to review this point in any forthcoming changes in the FSA's powers.

PURSuing COMPLAINTS

24. Regulation is a fundamental part of providing necessary protection for users by ensuring good quality services; but if "No regulatory system can absolutely guarantee consistently good standards everywhere",⁴ then it is essential, when things have gone wrong, that the interests of users are safeguarded through an adequate complaints system. In the interests of consistency and equity, such a system should cover quality issues for all health and social care services and treatments delivered in all settings, whether provided by the public, private or voluntary sectors, and irrespective of whether the purchaser is a statutory body, an insurance company or an individual.

25. Such a system should also be able to consider financial issues, particularly where complaints about quality of treatments or services are intertwined with concerns about their cost. The key point here is that extending the role of a single body, such as the NHS Ombudsman, to the private sector is unlikely to provide solutions for many people who do not currently have access to an appropriate, low cost mechanism for seeking redress because—in this example—the NHS Ombudsman lacks the powers to consider financial matters. Two examples, health cash plans and residents in residential and nursing homes, illustrate the problem. If people who have health cash plans feel that they have been poorly served, then they may have no recourse to complaint to an external body: few health cash providers are members of an independent complaints handling body such as the Personal Investment Arbitration Service or the Insurance Ombudsman Bureau. The sums of money involved are relatively small—though may be important to people on lower incomes—so that it is unlikely that the legal system will be appropriate, as legal costs may be far greater than the sums at stake.

26. For residents in residential and nursing homes, the Office of Fair Trading says that all should have clear, comprehensive, written contracts for their care.⁵ This is to be welcomed, but explicit contracts may not always exist for other types of care, or for treatments. Such contracts, where they do exist, may give some users a potential legal route for financial redress but, in the absence of any compulsion on the form and content of contracts, on its own a contract may prove insufficient protection for many users and patients.

27. As we have argued above, it is crucial to identify all groups of people who do not currently have adequate protections, and design new redress procedures to take account of all of them. If the NHS Ombudsman system is extended to include complaints about the quality of independent sector healthcare regardless of type of purchaser, then this should be developed hand in hand with mechanisms for working with the financial ombudsman schemes. We recommend that, where complaints involve both the quality of treatments or services and their costs, there is a clear mechanism for the NHS Ombudsman and the relevant financial ombudsman scheme to agree which body is to take the lead in investigating the complaint. Whilst both bodies should work closely to investigate their relevant elements of the complaint, the lead body would be responsible for reporting on the complaint in its entirety, taking advice on the particulars from the other

⁴ *Modernising Social Services*, Cm 4169, para. 4.3.

⁵ *Older people as consumers in care homes*, Office of Fair Trading, 1998.

body. At the moment, the plans for merging the different financial ombudsman schemes, and other developments noted above, risk leaving gaps in the private healthcare sector.

LESSONS FROM THE REGULATION OF SOCIAL CARE

28. In order to illustrate the importance of the points we are making about private healthcare, we include here a brief discussion of the government's plans for health and social care services for vulnerable people. These show that the government has already acted to create cross-boundary bodies to regulate an important area of public policy—so our proposals would, we think, be in line with current thinking. They also highlight the potential pitfalls of failing to create regulatory regimes which cover all of the people and organisations that can deliver care in domiciliary settings.

29. The Government has set out its intention, in *Modernising Social Services*, to create a new regulatory body, the Commission for Care Standards (CCS). Once established, the CCS will be responsible for the regulation of services such as:

- Residential homes (local authority, private and voluntary sector).
- Nursing homes (private and voluntary sector).
- Domiciliary personal social care providers (local authority, private and voluntary sector).

30. However, the proposals omit a range of services including independent sector home healthcare services delivered to people living in their own home, with relatives or friends, or in sheltered housing. This means that there will be inconsistencies in the treatment of similar services provided by social care agencies and independent home healthcare agencies. For example, both types of agency may administer and supervise an individual's medication; and both may provide catheter and pressure sore care. For one service provider to be regulated where another is not clearly leaves anomalies of the sort the Government appears to wish to see removed. An individual would receive regulated nursing care in a residential or nursing home but unregulated nursing care at their own home, even if the nursing tasks being carried out were identical in both settings. Further, whilst local authorities will be required to only contract with regulated domiciliary social care providers on behalf of users, the NHS will be free to contract with unregulated independent sector home healthcare providers, quite likely on behalf of the same vulnerable users.

31. A key question remains as to whether the NHS should be included in these regulatory proposals. Whilst this appears to be outside the immediate remit of the Committee's Inquiry, nonetheless it is an important issue. Firstly, not to do so will perpetuate further inconsistencies in the regulation system. For example, the increased use by the NHS of contracted independent sector nursing home places for those meeting NHS continuing inpatient criteria means that some vulnerable people will continue to receive care in regulated homes, whilst others do so in unregulated NHS nursing homes or other NHS long-stay provision. This would be in direct contrast with local authority arrangements where all places in residential or nursing homes, whether provided through a contract with the independent sector or direct provision in a "Part III" local authority residential home, would be regulated.

32. Secondly, it is important not to dismiss the NHS from consideration of the regulatory system, since it may become subject to regulation in the future in certain circumstances. For example, should NHS Trusts or Primary Care Trusts provide social care services as the integrated providers envisaged in the *Green Paper Partnership in Action*, these NHS-provided social care services would be subject to the proposed regulatory scheme.⁶

33. Failure to include independent sector home healthcare services, NHS home healthcare services, and NHS nursing homes and other long-stay provision within a regulatory system, will potentially leave many vulnerable users without the protection which the Government believes is necessary to secure for social care services. In the case of independent sector home healthcare services, this is of particular concern because there is currently no statutory complaints system, should things go wrong. However, the Government's plans for an Ombudsman service for complaints against a regional CCS exercise of its duties may not be sufficient, since this does not necessarily imply that complaints about standards of care in regulated services—as opposed to complaints about the CCS—will be investigated. It is also an example of the creation of a new ombudsman, which goes against the trends noted elsewhere, and against the integration which we argue is crucial to a successful system. We therefore recommend that lessons from the government's proposals for the regulation of social care are taken into account in the design of a regulatory regime for healthcare.

FINAL COMMENT

34. We believe that it is possible to act on a number of these issues without resort to primary legislation. The Secretary of State for Health has powers enshrined in statutes that allow him to act in a number of areas. To give an example relating to organisations, the Health Services Board was set up by the last Labour government to regulate pay beds and the size of the private sector.⁷ The Board was abolished in the Health

⁶ *Partnership in Action*, paragraph 4.40.

⁷ Under the Health Services Act 1976 (Chapter 83, Part II) and the National Health Service Act 1977 (Chapter 49, Sections 72-86).

Services Act 1980 (Chapter 53, Section 9), but the powers of the Board were transferred to the Secretary of State, who is therefore able to control the numbers of pay beds and of private hospitals if he or she wishes.

35. There is also an opportunity to influence forthcoming legislation. The current government has indicated that the NHS Modernisation Bill will include paragraphs that will modify the terms of reference of the GMC, currently defined under the Medical Act 1983, and introduce new arrangements for clinical governance. There is an opportunity here to influence legislation, and shape it to take account of the need to reform the regulation of private and independent healthcare.

If the Committee wishes to discuss this memorandum, or seeks further information, then in the first instance inquiries should be addressed to Dr Angela Coulter, Director of Policy and Development, King's Fund, 11–13 Cavendish Square, London W1M 0AN. (Tel: 0171 307 2693, Fax: 0171 307 2810, email: acoulter@kehf.org.uk).

SUMMARY OF RECOMMENDATIONS

Concerning Professionals

Create greater clarity within NHS consultant contracts about the rights and responsibilities of a commitment to the public sector.

Establish a standard requirement for information on the size of professionals' public and private clinical workload.

Ensure comprehensive coverage of healthcare professions within a consistent system of professional registration and self-regulation.

Promote government intervention to limit either the use of professional titles or the practices and roles that can be performed by unregistered healthcare professionals.

Give consideration to an overarching body responsible for the registration and self-regulation of all healthcare professionals.

Place an obligation on professionals working in the private or independent sector to participate in national audit or re-validation systems.

Concerning Organisations

Limit the employment of healthcare professionals within the private sector to those with professional registration.

Extend the obligation for systems of clinical governance to private and independent healthcare organisations.

Extend the inspection of healthcare by the Commission for Health Improvement to the private and independent sector.

Concerning Financial Regulation and the Pursuit of Complaints

All insurance and other financing organisations should be required to join an approved independent complaints scheme.

The role of financial regulators should be extended to cover the appropriateness of products.

These products should include all means of paying for healthcare, including health cash plans and the new payment schemes operated by some hospital groups for private individuals paying for treatment.

Where complaints involve both the quality of treatments or services and their cost, there should be a clear mechanism for the NHS Ombudsman and the relevant financial ombudsman scheme to agree which body is to take the lead in investigating the complaint.

Learning Lessons from Social Care

Lessons from the government's proposals for the regulation of social care should be taken into account in the design of a regulatory regime for healthcare.

January 1999

APPENDIX 23

Royal College of Paediatrics and Child Health (PM 48)

1. THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE

1.1 The Royal College of Paediatrics and Child Health (RCPCH) welcomes the opportunity to submit written evidence to the Inquiry.

1.2 The objects of the Royal College of Paediatrics and Child Health, established by Royal charter in 1996, include:

- to raise the standard of medical care provided to children, to advance the education of the public in child health which means the protection of children, prevention of illness and disease in children and safeguarding their optimal development.

1.3 The College is concerned about the health care of children in three sectors in the context of your Inquiry:

- the care of children who are private patients;
- the school health services in independent schools; and
- the care of children receiving complementary or alternative therapy.

2. THE CARE OF CHILDREN AS PRIVATE PATIENTS

2.1 The College has long been concerned about the standards of care provided to children admitted as private patients under the care of adult surgeons, anaesthetists and physicians both in NHS hospitals and outside. These concerns relate mostly to admission for relatively minor surgery, for example tonsillectomy, insertion of grommets, correction of squint, circumcision, and minor orthopaedic procedures. They extend across a wide range of specialities and our particular concerns are:

- the wide age range of children involved, often including infants and toddlers;
- the increasing number of children receiving private in-patient care;
- care provided by medical and nursing staff who have no specific training in children's health needs—for example these children are unlikely to be cared for by a trained children's nurse;
- failure to provide policies and protocols specific to the needs of children, and equipment appropriate to their size and age;
- poor pain management and lack of paediatric pharmacy support; and
- psycho-social aspects of the care of children are frequently ignored.

2.2 We are concerned that the healthcare of many children admitted as private patients fails to meet Department of Health standards as defined in "The Welfare of Children and Young People in Hospital", DoH 1991 or agreed guidance from the medical royal colleges and the Royal College of Nursing.

3. HEALTH SERVICES IN INDEPENDENT SCHOOLS

3.1 The college is concerned that the healthcare of some children attending independent schools, especially residential schools, does not meet the standards set out in the Department of Health document "Child Health in the Community: A Guide to Good Practice", 1996. Indeed it appears the legal duty to contract for school health services does not extend to independent schools (para 8.2.1).

3.2 The following statutory activities should be covered by the Community Child Health Services:

- children in need of protection and other children in need, including those with complex medical and social requirements under the terms of the Children Act 1989;
- children "looked after" by the local authority; and
- children who have special educational needs under the terms of the Education Act 1993.

3.3 We are concerned that these statutory obligations may not always be met in independent schools, and that there is no systematic monitoring of these services.

4. COMPLEMENTARY AND ALTERNATIVE MEDICINE

4.1 There is an important need to survey the extent to which children are attended by practitioners of complementary and alternative medicine. Anecdotally it would seem that a significant minority of children are taken by their parents to such practitioners: particular examples include concerns about food allergy, hyperactive behaviour, chronic fatigue syndrome (ME), and trace elements deficiency. We perceive an urgent need to define the extent of this consultation for children of all ages as a step to defining the safety, efficacy and evidence base of these therapies in the healthcare of children. We feel strongly that those practising complementary and alternative medicine must be able to show that their therapies are safe and effective.

5. We would be willing to expand on this brief written evidence and would welcome the opportunity to give oral evidence to the Inquiry if invited.

January 1999

APPENDIX 24

Memorandum by PPP/Columbia Healthcare Ltd (PM 50)

EXECUTIVE SUMMARY

PPP/Columbia operates its hospitals with clear lines of authority and responsibility for the overall quality of care. It supports the elements of clinical governance included in the Quality Framework for the Independent Sector being developed by the Private Practice Forum. [paragraph 2.0]

PPP/Columbia hospitals operate in accordance with the external quality standards such as The Health Quality Service in association with King's Fund and professional guidelines for consultants established by the Royal Colleges and others. Each hospital has a comprehensive programme of quality improvement including clinical audit, outcomes measurement, incident reporting and continuing education and training. [paragraph 3.0]

PPP/Columbia hospitals conduct and support post-graduate training for their own medical staff and referring GP's and other health care professionals. Most seminars and lectures have Continuing Medical Education (CME) recognition. [paragraph 3.6]

PPP/Columbia conducts a Training and Development programme for all staff. [paragraph 3.7]

PPP/Columbia supports the principles of the National Institute for Clinical Excellence and the Commission for Health Improvement. The private sector should be involved in developing common clinical standards. Implementation regulations are not yet fully defined but should be developed with private sector involvement to reflect differences between the sectors. [paragraph 3.9]

Each PPP/Columbia hospital has a formal complaints handling procedure, and adheres to the IHA Code of Practice on Patient Complaints that is currently undergoing revision. PPP/Columbia believes an independent Ombudsman should be included in the complaints handling procedures. PPP/Columbia supports the General Medical Council Code of Good Practice. However, while there is a formal complaint procedure that includes complaints against doctors practising in the NHS, and while complaints about doctors practising within private hospitals are handled through those hospitals, PPP/Columbia believes there should be a formal complaints handling process for specialists private clinical practice. At present there is no procedure for a patient to complain about a doctor. [paragraph 4.0]

PPP/Columbia supports the regulation of all providers in the private sector. Hospitals licensing requirements should be separated from those aimed at nursing homes. Regulations should address the quality of facilities and their appropriateness to the level of care, and the standards of the services provided whether emergency, acute; or cold surgical procedures. Current unregulated providers—cosmetic surgery, minor surgery and NHS pay beds should be included in this framework. [paragraph 5.0]

1.0 PPP/Columbia Healthcare is a partnership of PPP healthcare group plc and Columbia/HCA Healthcare Corporation that owns and operates four acute care hospitals in central London: The Wellington Hospital; The Princess Grace Hospital; The Portland Hospital for Women and Children; and The Harley Street Clinic.

These four hospitals have a total of 600 beds, have granted admitting privileges to over 650 specialists, and employ over 1,500 healthcare personnel.

They provide a comprehensive range of medical services, and emergency, acute and cold surgical procedures that include:

- 996 adult cardiac surgeries at The Wellington Hospital and The Harley Street Clinic in 1998
- 265 paediatric cardiac surgeries at The Harley Street Clinic in 1998
- nearly 1,800 births at The Portland Hospital for Women and Children in 1998

Approximately 21,000 patients from the UK and overseas were admitted to our hospitals in 1998.

2.0 PPP/Columbia operates its hospitals with clear lines of authority and responsibility for the overall quality of care. It supports the elements of clinical governance included in the Quality Framework for the Independent Sector being developed by the Private Practice Forum.

2.1 The Chief Executive Officer of each PPP/Columbia hospital is responsible for the granting, suspension, or withdrawal of specialist admitting privileges. These actions are undertaken in consultation with the Medical Advisory Committee (MAC). Each specialist signs a letter of appointment agreeing to the conditions of working in the hospital. APPENDIX 1.¹

¹ Appendices not printed.

2.2 Specialists working in our hospitals are independent contractors who have been granted admitting/practising privileges after careful review, Hepatitis B check, reference check and inquiry by the MAC of each hospital. Minimum criteria are the current or recent tenure of a substantive NHS Consultant post or accreditation following higher specialist training in the relevant speciality to be practised. Further accreditation for specialist procedures may be required particularly where new techniques are being proposed or authorised.

2.3 The MAC of each hospital has membership from representatives of the major specialities at that hospital. The Chief Executive and Chief Nurse are in attendance. Meetings are held regularly to discuss clinical issues within each hospital to allow guidance and support to management and representation of the views of the Consultant body of the hospital. Sub-committees are also invoked for the further discussion of special areas of activity. Additionally, speciality meetings consisting of all specialists in that speciality are held for the evaluation of clinical activity and for continuing education. The Chairman of the MAC plays an important role in the hospital to enable medical colleagues to voice their opinions and participate in the formulation of policy and guidelines for clinical management.

2.4 All PPP/Columbia hospitals have a Resident Medical Officer (RMO) programme. At least one RMO is always present within each hospital and is trained in Advanced Life Support techniques. These posts are generally made in conjunction with an adjacent Teaching Hospital or Medical School and the doctors appointed are usually well advanced in their CALMAN training. RMO's are clinically responsible within the hospital to the Chairman of the MAC.

2.5 The Portland Hospital additionally has a Consultant Resident Programme for obstetric anaesthesia and employs the lead Consultant on staff.

2.6 A Resident Intensivist Programme to include the Portland Hospital, The Princess Grace Hospital and the Harley Street Clinic is currently being recruited for. This innovative lead is being made in conjunction with our colleagues at The London Clinic and King Edward VII Hospital. The Wellington Hospital already supports a cardiac based Intensivist Programme, the only accredited plastic surgery Fellowship Rotation in the independent sector, and dedicated psychiatric RMO. APPENDIX 2.

3.0 PPP/Columbia hospitals operate in accordance with the external quality standards such as The Health Quality Service in association with the King's Fund and professional guidelines for consultants established by the Royal Colleges and others. Each hospital has a comprehensive programme of quality improvement including clinical audit, outcomes measurement, incident reporting and continuing education and training.

3.1 All of the four hospitals participate in The Health Quality Service in association with the King's Fund and are currently all fully accredited. Two hospitals have achieved The Investors in People Award and the other two are preparing for this. The medical laboratory, which serves the hospitals, has accreditation from the CPA.

3.2 Each hospital currently conducts and will continue to expand clinical audit. The Princess Grace Hospital has appointed a senior consultant to supervise audits. In specialist areas of activity data collection and audit within national guidelines is undertaken. The cardiologists already participate in the national audit set up by their professional body (BCS) and our cancer statistics are submitted to all relevant data registries. Participation in NCEPOD is ongoing. APPENDIX 3.

3.3 PPP/Columbia hospitals subscribe to a national/international audit/outcome measurement programme, QUIPS, which allows benchmarking of outcomes using standardised parameters. APPENDIX 4.

3.4 A comprehensive computerised patient administration system, which includes access by medical staff, assists in accurate collection of data and the ability to retrieve information for review.

3.5 PPP/Columbia has a Risk Management and Health and Safety Programme. Each hospital has its own Health and Safety Committee and responsibility and accountability is distributed throughout the entire management body of each hospital. Both patient satisfaction surveys and employee attitude surveys are regularly conducted to identify opportunities for improvement, and adverse incident reporting is routinely monitored and reported.

3.6 PPP/Columbia hospitals conducts post-graduate training for their own medical staff and referring GP's and other health care professionals. Most seminars and lectures have Continuing Medical Education (CME) recognition. The Wellington Hospital annually holds symposia in plastic and re-constructive surgery, specialist knee surgery, and hand therapy. These conferences attract international speakers and participants, and are recognised for CME Accreditation. Medical staff also participate in and attend audit and review meetings in their speciality.

3.7 PPP/Columbia conducts a Training and Development programme for all staff. Appraisals of clinical staff identify clinical and management training needs and professional development plan are supported for all employees. Clinical staff participate in the training of course students on secondment to our hospitals and formal links are established with The South Bank University and City University.

3.8 90 per cent of PPP/Columbia nurses are Registered General Nurses, many have post-registration qualifications. Registered midwives are supported by nursery nurses. Radiography, physiotherapy, pharmacy, laboratory and occupational therapy staff all have the appropriate qualifications for the speciality.

Nursing staff in particular facilitate Working Groups in many areas of clinical practice to promote development and standard setting. These groups report their progress to the MAC and in some instances membership will include medical staff.

3.9 PPP/Columbia supports the principles of the National Institute for Clinical Excellence and the Commission for Health Improvement. The private sector should be involved in developing common clinical standards applicable to both sectors. Implementation regulations are not yet fully defined but should be developed, with private sector involvement to reflect differences between the sectors.

4.0 Each PPP/Columbia hospital has a formal complaints handling procedure, and adheres to the IHA Code of Practice on Patient Complaints that is currently undergoing revision. PPP/Columbia believes an independent Ombudsman should be included in the complaints handling procedures. With respect to complaints about doctors, PPP/Columbia supports the General Medical Council Code of Good Practice. However, while there is a formal complaint procedure that includes complaints against doctors practising in NHS, and while complaints about doctors practising within private hospitals are handled through those hospitals, PPP/Columbia believes there should be a formal complaints handling process for specialists private clinical practice. At present there is no procedure for a patient to complain about a doctor.

5.0 PPP/Columbia supports the principle that all providers in the private sector should be regulated. Hospital licensing requirements should be separated from those aimed at nursing homes. Regulations should address the quality of facilities and their appropriateness to the level of care, and the standards of the services provided whether emergency, acute; or cold surgical procedures.

Current unregulated services—cosmetic surgery, minor surgery and NHS pay beds should be included in this framework.

5.1 PPP/Columbia hospitals are all registered by the Kensington, Chelsea and Westminster Health Authority. In addition the hospitals are inspected by other authorities such as the Fire Brigade for fire safety and the Home Office for the regulation of drugs. All laws that monitor safe practice such as the Ionising and Radiation Protection Act and the Termination of Pregnancy Act are adhered to.

5.2 The Wellington Hospital operates a designated plastic and re-constructive surgery unit. Surgeries are only performed by accredited specialists in plastic and re-constructive surgery. The unit is under the direction of a core group of senior consultants, and is staffed only by senior nurses working only in that speciality. There is a programme of continuing training for the nurses and The Wellington Hospital regularly hosts international conferences accredited for CME credits. The plastic and re-constructive surgery unit at The Wellington has the only accredited plastic surgery Fellowship in the independent sector.

5.3 Under the Nursing Homes Act, a hospital's license is vested within the Chief Nurse. Hospital licensing should be separated from nursing homes to recognise the complexity of medical and surgical services, and to vest the license and full responsibility and accountability for operations and quality with the Chief Executive.

January 1999

APPENDIX 25

Memorandum by Caroline Buckley (PM 54)

THE BURWASH CASE

My name is Caroline Buckley I am the daughter of the late Carole Burwash who died in October 1995 at 53 years old following a catalogue of errors at the private Princess Grace Hospital in London. My mother was killed owing to medical negligence for which the hospital admitted full liability.

I myself am 34 years old and have four children aged eight, seven, five and three. I am also a fully qualified nurse, having trained at the Middlesex hospital in London. I have not worked however since the birth of my first child in 1990.

I feel that it is relevant to give this information so that the committee is aware of my understanding of the situation; not only as a now unfortunately knowledgeable bereaved relative, but also from my previous medical knowledge and experience.

Being a founder member of APROP (Action for the Proper Regulation of Private hospitals) I obviously wholeheartedly support, represent and uphold everything noted and recommended in the first file, but this is my personal statement on my mother's death alone and the lessons to be learned from it.

Our case has had an enormous amount of press coverage and prior to APROP's formation my father and I pursued meetings with the Department of Health. We tried to ensure that proper inspections were carried out at the Princess Grace hospital so that the systems that had let us down so badly were changed and new protocols put in place.

I then became more and more aware that there was a much wider issue surrounding my mother's death at a private hospital. It was obvious that not only was my mother's death not an isolated incident, but that it had been an accident waiting to happen. The Princess Grace although totally negligent in its own right was merely symptomatic of all private hospitals.

I feel very strongly that the whole private sector in this country urgently needs to be shaken up and regulated so that I can ensure that my mother did not die in vain and that something good has come from our tragedy. We must prevent other families going through what we have had to endure.

I enclose for your information a copy of the report by the independent medical witness Professor Felicity Reynolds who was asked by the coroner to give evidence at the inquest after my mother's death¹. It backs up all of my points.

My mother was admitted to the private Princess Grace hospital for a routine hysterectomy owing to menopausal problems. She was otherwise in very good health.

She was admitted early on Wednesday 15 October 1995, with her operation scheduled for 5.00pm that afternoon. She was put in a room at the end of a corridor, a long way from the nurses' station, with a door that did not stay open owing to a faulty mechanism.

During the afternoon she was visited by her anesthetist Dr Lim and was advised that the best post-operative pain relief with minimum sickness would be an epidural directly into her spinal column administering opiate drugs.

I spoke to her just before the operation and then spoke to her again post-operatively at about 21.45 when she was back in her room. The operation had apparently been successful and she was very relieved to have come through it and to be in so little discomfort.

My father and one of my brothers were with her, and I suggested that when they left she should "buzz" the nurses and ask them to settle her for the night. I assumed that a top-up would be given to her epidural. I phoned back about twenty minutes later and spoke directly to the nurses' station, as I did not trust my mother to have called them for fear of disturbing them. I was told that she had indeed been seen and that she had been given 30mg of diamorphine to settle her for the night.

I specifically remember querying this with my husband (who is non-medical) as I recalled much smaller quantities of diamorphine being administered when I was nursing. We agreed however that I had been out of nursing for a little while and that we should trust her care to the professionals at the Princess Grace. We eventually went to sleep.

I was woken at 01.30 that night (very early Thursday morning) by a telephone call from my father who told me that my mother's surgeon Mr Pugh had phoned him to say that there had been an accident, my mother had been given an overdose and she was now in intensive care. I left for my father's house immediately after working out childcare with my husband as we had four children under five and a half, our youngest being only five months old and still being breast-fed.

I collected by father and we drove straight to the Princess Grace. Both of my younger brothers joined us later on in the night.

We were eventually told that my mother had been prescribed 3mg of diamorphine but had been given a ten times overdose of 30mg directly into her epidural. She had lost consciousness, resuscitation had been initially unsuccessful, and she was unconscious in a very serious condition in the intensive care facility at the Princess Grace. We all (both family and medical staff) agreed that the intensive care unit at the Princess Grace did not have the experience, staff or equipment that we needed and so my mother (still unconscious) was transferred to the Middlesex Hospital at 05.30 that Thursday morning.

We stayed at the Middlesex for the next three days where the NHS staff tried valiantly to pick up the pieces and save my mother. Despite all their best efforts this proved impossible and at 12.55pm on Saturday 21 October my mother was pronounced brain dead and her life support was switched off.

We had all of her organs donated.

She was only 53 and had been needlessly killed. It devastated our family. My father and my two younger bachelor brothers were very reliant and dependent on her. Her four young grand-children could not understand what had happened and would now never have their adoring and adored grandmother as part of their lives.

Being the eldest child and only daughter I held the family together and resolved to find out exactly what had happened and to ensure that it could never ever happen again.

I will briefly list the main issues concerning my mother's death, and then expand on some of the key areas, but they all fall under one heading—REGULATION. If private hospitals in general and the Princess Grace in particular were properly regulated I believe that my mother would be alive today.

It transpired that what had happened in my mother's case was:

- as mentioned Dr Lim decided on epidural opiates as the best form of pain relief;
- that night at the Princess Grace once the operating doctors had left there was only one doctor on the premises, a RMO (Resident Medical Officer) Dr Hornabrook;

¹ Not printed.

- Dr Lim never checked with Dr Hornabrook whether he was familiar with and comfortable with epidural opiates. In fact Dr Lim never spoke to nor met with Dr Hornabrook at all before my mother's operation;
- Dr Lim never checked with the nursing staff either;
- Dr Lim prescribed 3mg of diamorphine post-operatively;
- Dr Hornabrook and the nurse in charge of that floor (staff-nurse Hatcher) being unfamiliar with epidural opiates and Dr Lim's methods and hand-writing mis-read the drug chart and gave my mother a 30mg injection, a ten-times overdose;
- the nurses visited my mother twice after the over-dose and found her "un-rousable". This was put down to a heavy sleep. They missed all the signs of respiratory depression;
- finally they realised she was unconscious and had stopped breathing and pushed the emergency buttons;
- the only doctor on duty (Dr Hornabrook) rushed to her room and began attempted resuscitation;
- Dr Hornabrook, the only doctor on duty, had not taken nor had been required by the Princess Grace to have the ACLS (Advanced Course in Life Saving techniques);
- for forty minutes Dr Hornabrook was unable to put an air-tube into my mother's throat in order to resuscitate her;
- finally Dr Lim was recalled from his home to the hospital where he was able at the first attempt to put the air-tube in; and
- it was too late as my mother never regained consciousness and had her life support machine switched off three days later.

I repeat that if private hospitals in this country were properly regulated my mother would be alive today. I believe that most private hospitals fall below standards of care achieved in the NHS and the lack of inspections and regulation means that this will continue until there is a change in legislation to ensure that these hospitals must adhere to certain laid-down criteria, standards and protocol.

I also know that this is a feeling well believed within medical staff working within the NHS. Ask any doctor at any level whether he would have his operation privately or on the NHS and he will play safe, ignore the lack of privacy and the standards of hospital cleanliness and pick the NHS every time. The private sector simply cannot give you the required back-up.

If the inspectors that do go into private hospitals (such as the one I met at a meeting at the DOH) were better qualified, better informed, but most importantly had a laid-down code of practice they could enforce, then the private hospitals would have to improve their standards.

The current legislation covering Private Hospitals (the Registered Homes Act 1984) is currently so archaic that none of the acute clinical issues are addressed at all. There are simply no standards for these hospitals to adhere to in this area. One just wonders how many more mothers need to die??

To re-visit some key areas where my mother's situation would have been improved or avoided with proper regulation:

Communication: in the NHS the patient is looked after by the team of their consultant who post-operatively will pass down information to the team looking after the hospital over-night. As mentioned my mother's anaesthetist never spoke to the RMO nor the nurses pre or post-operatively. He simply performed his duty in the operating theatre and went home. Only to be called out for the emergency later.

The current system whereby consultants "rent" rooms and facilities in private hospitals for the duration of a patient's stay but then leave without checking is very negligent. They are putting their patient's care in the hands of mainly unknown individuals (especially if agency staff are involved) whose standards are unknown, un-regulated and are not maintained.

The use of complicated analgesia by unknowledgeable and inexperienced staff: my mother's was the first epidural that Dr Hornabrook and staff nurse Hatcher had ever topped up with an opiate and indeed was only the second epidural that year that they had dealt with. Indeed when questioned by me about the 30mg dose the nurse showed a distinct ignorance and lack of basic knowledge of opiates.

Had my mother been in a NHS hospital she would have been nursed in intensive care to enable the staff to monitor the unpredictability of this drug regime. Even the originally prescribed dose of 3mg can cause complications in some patients.

Post operative observations: the nurses checked my mother twice after the overdose had been given and failed completely to spot the obvious signs of respiratory depression. Had they noticed and acted upon it she may well be alive today.

At the inquest it was discovered that there were no laid down procedures for post-operative observations. There should be some protocols for the inexperienced nurse. The nurses should have spotted the very quick nature of my mother's onset of "sleep". Alarm bells should have rung.

Adequate training, specifically in resuscitation: to have one resident medical officer on duty over- night within a large hospital with over 100 beds with acute patients and post-operative surgery to look after is ridiculous. More ridiculous however is that he was not (and was not required to be) qualified in resuscitation techniques, including intubation. Every patient at the Princess Grace that night (and indeed any other night when Dr Hornabrook was on duty) was at risk.

I do not hold Dr Hornabrook (who I have met twice) personally responsible. Nor does Professor Reynolds in her independent report. Obviously he made a grave and careless mistake but he should not have been put in such a position. He needed back-up. I believe that all RMO's left in charge of a hospital overnight should have as a minimum the ACLS course which is a short course in refreshing doctors' memories in resuscitation techniques specifically intubation. It must be remembered that many doctors are able to and indeed do get to this level with very little resuscitation experience. This course should be part of the standards and rules that every hospital has to adhere by.

Room positioning: a major abdominal operation at the end of a corridor with very few post-operative observations to refer to? Why not ensure that all major cases are centrally positioned and that all of these rooms and patients have alarmed pulse-oximeters to alert staff of problems arising. One of the main reasons that people use the private sector is the privacy of their own rooms and on-suite facilities: but they are unaware of the risks. If someone had been with my mother or been alerted just before she stopped breathing she may well be here today.

The total injustice of all these points is worsened by the fact that when mistakes happen these private hospitals cannot cope and simply dial 999. An ambulance arrives and the private patient is transferred to the local NHS hospital that has to pick up the bill from then onwards. The private hospital declines all responsibility from that point.

As mentioned I have attached the report prepared by Prof Felicity Reynolds for the inquest, and I have highlighted key areas of interest. She is very understanding and sympathetic of our cause as are many doctors at her level.

I have not even touched upon the other major area of concern involving private hospitals and that is a lack of a proper complaints procedure. Although this has affected many other members of APROP, we were "lucky" in that the Princess Grace admitted full liability (even though it took them four months) and so we never had to make a formal complaint.

I finish my statement in the hope that I have managed to relay clearly our family tragedy and that I have pointed out in a balanced way how this could and would have been avoided had proper regulation been in place at the Princess Grace that night.

I would welcome the opportunity to give oral evidence to the Health Select Committee whom I have observed at a sitting. I was very impressed by their diverse knowledge of wide areas of information.

I thank you for taking the time to read this and hope to hear your feedback and ideas in due course.

APPENDIX 26

Memorandum by the British Dental Association (PM 57)

EXECUTIVE SUMMARY

1. The BDA is the UK's leading national professional dental association with 17,000 members in all spheres of private, NHS and mixed NHS and private practice. Recent research has shown that twenty four per cent of patients receive some of their dental care privately in general practice. The Association therefore has a particular interest in the regulation of private health care.

2. There is currently no formal, statutory complaints procedure for patients receiving private dental care. This is unacceptable and must be overcome urgently. Two possibilities of addressing the problem are currently under review.

3. Private dentistry must of course continue to be regulated. But we feel that, at this stage, a *separate* system of regulation and inspection for private dental practitioners would not be a good use of public money and is not warranted. It is essential, on the other hand, that existing and future mechanisms for quality control in NHS dentistry are extended to include private dentistry, especially in view of the increased emphasis on clinical governance and continuing professional development in the NHS.

4. The basis of this view is twofold. Firstly, whilst it is clear that private sector dentistry will increase, most dentists, whether in general or specialist hospital practice, also practise within the NHS. Secondly, commercial considerations and higher patient expectations exert greater pressure on private practitioners to maintain standards and there is no evidence that private dental care is being provided to a less than acceptable standard, nor at unreasonably high cost. On the contrary, the ability to charge fair fees which relate closely to the real cost of service provision means that dentists can provide a higher standard of service and clinical care when they can spend more time, employ higher quality staff and use better materials and laboratories.

5. This situation must be kept under constant review as the proportion of private dentistry inevitably develops. In preparation for clinical governance, monitoring and dental service planning, connection of every practice to the NHSnet would allow activity monitoring to develop and enable the advantages of the NHSnet for improving patient care to be shared by private patients.

INTRODUCTION

6. The British Dental Association is the largest professional association for dentists in the UK with 17,000 dentist members from all spheres of practice. The Association is a trade union, scientific society and professional association. Most dental care, whether NHS or private, is provided in general practice. The BDA's Private Practice Committee supports dentists providing care to patients under private contract in general practice, while its Central Committee for Hospital Dental Services (CCHDS) deals with both NHS and private dental care in hospitals. CCHDS is represented on the BMA's Private Practice Committee, whose submission to the Inquiry we support.

7. The amount of private dental care provided has been increasing steadily in recent years and, with current trends in NHS funding for dentistry, this will continue. Private dental care is, in the main, provided in dental practices providing a mixture of NHS and private care: there are only an estimated 500–1000 dentists who provide exclusively private care, and 20,000 others who have a mix of private and NHS patients. Our research has shown that, in 1998, 24 per cent of the adult population received their dental care privately. In 1996, 73 per cent of general dental practitioners were seeing more than 75 per cent of their patients on the NHS but in 1998 only 63 per cent did so. Dentists and dental patients therefore have considerable experience of the delivery of private health care and its potential benefits in terms of quality of care.

8. Private dental care may be provided to registered NHS patients under mixing arrangements; and to wholly private patients as part of a capitation/insurance scheme, or under a fee per item contract, independently negotiated between dentist and patient, and based usually on an hourly rate.

COMPLAINTS ABOUT PRIVATE DENTAL CARE

9. Poorly handled or unresolved complaints cause serious anxiety and distress for patients and dentists. Currently, dentists have a professional requirement (contained in the General Dental Council's guidance to dentists, *Maintaining Standards*) to have a formal complaints procedure within their practices for both NHS and private patients. The BDA in 1996 issued detailed advice to all its members on handling complaints, which included a model procedure (attached at Appendix A).

10. Private dentistry is hampered by the lack of a universal and independent complaints procedure, a situation which cannot be allowed to continue. Where complaints cannot be resolved through the dentist's in-practice procedure, the patient's only current recourse is to seek redress by litigation or to make a complaint of serious professional misconduct to the General Dental Council. The Council is able to address complaints only in the limited circumstances where serious professional misconduct is alleged. Since many dental complaints have simply resulted from a breakdown in communication between dentist and patient or relate to charges and so may not amount to professional misconduct, complainants can feel very dissatisfied with the present lack of an organisation from which they can seek help and a swift resolution.

11. NHS dental care has a structured complaints process which enables complaints to be resolved by conciliation or independent review. Many of these complaints might, if they had concerned private care, have resulted in expensive, lengthy litigation.

12. The General Dental Council has for some time been pressing for an amendment to the Dentists Act 1984 to allow it to set up a statutory private patient complaints procedure. The BDA has also considered establishing our own non-statutory scheme, but, as a voluntary organisation, we cannot require dentists to pay for or participate in a scheme, nor can we impose decisions or sanctions. We may also be seen by the public not to be impartial.

13. The profession has reservations, however, about a procedure run by the regulatory body, since it would be too closely linked with the disciplinary process from which it should be seen to be quite distinct. We have been interested to learn recently that the Academy of Medical Royal Colleges is considering establishing a complaints scheme which would have a statutory basis and would include all the health professions, a move which we welcome.

14. An additional complication with private complaints is that many may relate to the "mixing" of private treatment with NHS treatment. We support the ability of dentists to mix in this way, as we believe it offers increased options for patients. It is, however, important that the NHS and private complaints schemes are seamless and transparent.

15. Our strong recommendation to the Committee is that efforts to establish a statutory, independent complaints scheme for private patients are supported.

REGULATION AND INSPECTION

Regulation

16. All dentists are subject to regulation by the General Dental Council. Where private dental care, which is based on an individually agreed contract between dentist and patient, has been provided with insufficient skill and attention, or where patients have been misled about the nature of the contract they have entered into, the dentist may be subject to proceedings for serious professional misconduct and erasure or suspension from the Dentists Register.

17. The General Dental Council also requires certain minimum safeguards to be provided for all patients. These provisions ensure that private dental practice is not unregulated and include the following requirements:

- the patient must be clear about the nature of the contract, whether it covers NHS or private dental care and must give valid consent to the treatment to be provided;
- the patient must be given information about the estimated cost of treatment;
- emergency cover must be provided;
- necessary care and treatment must be provided to a high professional standard; and
- dental care must be provided by a registered dentist or an enrolled dental auxiliary.

18. The BDA issues detailed advice to members on their ethical and legal requirements in providing a high standard of service to their private patients. This advice has been adopted widely and has contributed to a general improvement of practice standards.

19. All dentists must also comply with a wide range of general legislation including that relating to health and safety and consumer protection. Again, the BDA provides detailed advice on these.

20. GDC arrangements in the future for regular reaccreditation and recertification as a requirement of continued registration and the right to practise, as well as performance review, will apply to all dentists.

Inspection

21. General dental practitioners with NHS list numbers (those who provide NHS dental care to at least one patient in a six month period) are also subject to General Dental Services regulations. For example, Health Authorities may inspect their practices and dentists must provide a patient information leaflet containing basic information. Given that most dentists have list numbers and that even those practices which are almost wholly private contain at least one dentist providing care under the NHS, we estimate that over 95 per cent of general dental practices have to undergo inspection. Dentists who wish to provide care under the major private dental plans (for example Denplan or BUPA Dental Cover) must also undergo assessment or inspection and meet certain criteria. Practice inspections are also mandatory for dentists wishing to participate in the Dental Vocational Training Scheme. Dental practice inspections cover such issues as compliance with health and safety and general legislation, practice equipment and facilities.

22. Dentists providing private dental care are subject to greater commercial pressures to adopt high standards of care and service. When providing private dental care, dentists must satisfy increased patient expectation, a very significant factor in effective self-regulation. The emergence of a large private sector is relatively recent, however, and there is as yet no evidence relating to the quality of private dentistry.

Integration

23. In view of the above provisions, the Association does not believe that different regulatory or inspection requirements should at this stage be established for dentists providing private care. Because of the apparently inevitable shift towards private practice, this situation must be kept under review. It would be much more cost-effective to ensure that existing provisions for regulation and quality control in NHS practice are extended to include those working in wholly private practice. Mechanisms should be made available by the Department of Health to support the integration of private dentists.

QUALITY CONTROL AND CLINICAL GOVERNANCE

24. Most dentists who have shifted the emphasis of their practices towards the private sector have done so because they have not felt able to provide a high standard of service at NHS fees. Relating their fees to the actual cost of the service and a fair return on their investment, coupled with operation in a free market, has, we believe, had a beneficial effect on quality.

25. If clinical governance is to be a reality in dentistry it must encompass private care. The Association shares the Department of Health's desire to improve quality and standards within the NHS. The White Paper *A First Class Service* did not explicitly apply clinical governance to private dental care, but in our supportive response to the Paper, we made the point that private dental practice must not be forgotten. Currently dentists

in purely private practice do not have access to clinical audit and peer review nor to NHS continuing education arrangements and vocational training. Once again, whilst this might exclude only a very small minority of dentists at the moment, this situation could change and must be addressed now.

PRIVATE CHARGES

26. We believe that market forces should operate to control private dental charges, as with other professional fees, and have no evidence that there is a significant problem with the level of charges. It is, however, essential that patients are clear about the cost of their private treatment and the Association is developing a communications initiative for dentists.

PRIVATE DENTAL PLANS AND INSURANCE

27. Responding to the growth of private practice, there are a number of private capitation plans and insurance schemes and it is estimated that approximately one million patients are covered in this way. These have generally been welcomed by dentists and patients as providing another option for patient choice. Some capitation schemes have their own arrangements for patient complaints and quality control.

MONITORING

28. Currently, the Dental Practice Board monitors the work of dentists providing NHS care and the payment system means that very valuable, detailed information is gathered on treatment provided—probably the most detailed in the health service. The monitoring system also looks at the quality of clinical care, compliance with GDS Regulations and the type and amount of care provided by a dentist in comparison with others. The Dental Practice Board reviews trends through statistics on payment claims and patient examinations by Dental Reference Officers. The information produced is useful for dentists themselves who receive profiles of their practising patterns and is invaluable nationally and locally to the health service in oral health care planning.

29. These benefits do not extend to private dental care. There is no information exchange and serious cases of poor clinical standards still may only come to light following a complaint to the General Dental Council. One possibility for enabling the introduction of some form of monitoring and information gathering might be to link every practice to the NHS net and include dental information in the planned Electronic Patient Record.

CONCLUSION

30. This is a necessarily brief account of the BDA's position on private dental practice. Whilst we are active in our support for NHS dentistry, we believe that the growth of the private sector has been and will increasingly be a positive influence in the standards of patient care. Because the sector is young, there is as yet little evidence to confirm this and we would welcome on-going research into the effectiveness and outcome of private dental care. Private dentistry must be regulated and monitored, however, and complaints and quality control systems must apply to it. Whenever possible, existing systems should be extended and transparent and seamless structures developed.

31. The Association would be pleased to provide more detailed information and to present oral evidence if required.

January 1999

APPENDIX 27

Memorandum by the Association of Directors of Social Services (PM 60)

SUMMARY

1. The independent healthcare sector has expanded considerably over the last 20 years and covers activity from acute hospital to community health care. Whilst growth has slowed, the private and independent sector is a major supplier of nursing home care and relief nursing cover for the NHS.

2. A more coherent and consistent process of regulation and monitoring of independent sector healthcare services outside the NHS and for long term care facilities within it is needed. This is necessary to reflect the changing scale and range of provision with special reference to the needs of dependent and vulnerable people.

3. The regulation of Nurses Agencies should be brought within the scope of the proposed eight regional Commissions for Care Standards.

4. Regulatory regimes for acute care and nursing care should be separated and a single framework should be applied to nursing and care homes. The latter would assist in supply side rationalisation and the longer term development of provision consistent with new national required standards.

5. Directly provided NHS long term care should be subject to regulation on the same basis as similar independent health care provision outside of it. The development of new forms of “Intermediate Care” involving more flexible and adaptable forms of health and social care raises issues surrounding the regulation of such care and its NHS interface.

6. Local people should be involved in the regulation of independent healthcare. Processes of “open reporting” and “lay involvement” should find appropriate expression within future regulatory responsibilities for nursing homes and agencies.

7. The continued regulation of independent hospitals providing acute care within the framework of the Registered Homes Act, 1984, should be reviewed along with the responsibility for such functions which often involves Health Authorities in both a commissioning and regulatory role.

8. Complaints processes should be strengthened and access to complaints procedures clarified in relation to commissioning and regulatory responsibilities of health and the new Commissions for Care Standards.

CONTENTS

ADSS MEMORANDUM OF EVIDENCE TO HEALTH COMMITTEE

1. Expansion of private and independent healthcare
2. A need for a more coherent framework
3. Nurses Agencies Act 1957
4. Nursing Homes
5. Evenhandedness in regulation
6. Resourcing, local accountability and involvement
7. Intermediate care
8. Regulation of private hospitals
9. Strengthening of complaints processes
10. Importance of effective healthcare regulation
11. Text references

REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE

1. THE EXPANSION OF INDEPENDENT HEALTHCARE

1.1 The most accessible source of general information on the growth of private and independent healthcare is “Laing’s Healthcare Market Review” published by Laing and Buisson. The Review of 1998–99[1] confirms:

- Independent hospital and nursing home expenditure has increased from around 10 per cent of the total NHS and independent sector spend in 1986 to around 20 per cent in 1997. [table 1.1]
- The NHS purchases around £460 million within the independent healthcare sector for acute, psychiatric and long-term care.
- Most of the expansion within the independent healthcare sector has been in the growth of nursing home care which in 1997–98 represented just under 50 per cent of total independent sector supply of healthcare in the UK of £14,538 million. [table 1.2]
- This growth in independent sector provision reflects the continuing redefinition of NHS responsibilities, the impact of demographic change and changed attitudes to the provision of long-term care within institutional settings.

1.2 This inquiry is timely. Whilst there has been a lot of debate surrounding social care regulation, less attention has been focused on regulatory frameworks for private health care. These arrangements have been left largely unchanged for many years, although the private and independent health care sector has expanded considerably. There have also been changes in NHS structures and in the way the NHS operates. During this period social services departments have become major purchasers of independent healthcare in the form of nursing home provision.

1.3 ADSS considers regulatory frameworks should keep pace with the changes in the provision they seek to regulate and in interfaces between different commissioners and sectors of provision. The New NHS White Paper [2], set out a new approach to commissioning and expectations surrounding quality in health care. The report of the Royal Commission on Long-Term Care may reshape the future balance of funding responsibilities between the NHS, social services, and the individual. Recent guidelines for mental health

frameworks [3] may also affect independent healthcare provision. It seems reasonable to suggest that future regulatory arrangements for independent health care should assume:

- Continued reductions in NHS provision of long-term care for older people. [4]
- Closure of most long stay hospitals for people with mental disorders and a continued move away from secondary care led mental health services towards a primary care led framework involving closely co-ordinated health and social care provision in the community and more use of the independent sector.
- A growing erosion of distinctions between health and social care support of dependent people within the community as joint working between health and social care develops. [5]
- Continued and, perhaps, increased use of social security benefits and direct payments for nursing and social care to continue independent living and of private medical insurance for access to independent acute care; including day activity.
- Continued clinical progress involving provision of acute care within shorter timescales and a wider range of treatments within expanded primary care settings linked to an expansion of “community” health and social care services.
- Continued growth in “intermediate” care within the community and in settings outside of the NHS acute sector in response to changes within the NHS to improve rehabilitation and manage “Winter Pressures”. [6]
- Increased numbers of older people in acute settings and use of convalescent care within the independent sector as a means of securing better care outcomes amongst those people who might otherwise be placed in permanent residential, nursing or other settings.

1.4 The underlying demographic pressures on the acute sector of the NHS are likely to be the most significant driver of change and in shaping use of private and independent healthcare. In 1997–98, for example, it was estimated that around 19 per cent of acute beds in the NHS were occupied by people aged over 85 compared with 9 per cent in 1970. An estimate for 2010 suggests this figure will rise to around 25 per cent.

1.5 The 1998 Laing’s Healthcare Market Review draws attention to the “lack of any tradition” of NHS provision of nursing homes [p40]; although, some NHS Acute Trusts have shown signs of developing such provision under PFI initiatives. Most NHS long term provision continues to consist of wards. Many would not meet registration standards for long term provision within the independent sector and, increasingly, are unlikely to meet public expectations of care.

1.6 Underlying the question of the adequacy and extent of the regulation, monitoring and inspection of healthcare outside of the NHS, therefore, is a much more fundamental issue: what is likely to be the role of and scope of independent healthcare within England and Wales? In summary, future regulatory frameworks for independent healthcare need to be consistent with the markets they regulate; the rising dependency and vulnerability of users within them; and, the increasing awareness and expectations of the wider public and patients.

2. THE NEED FOR COHERENT AND CONSISTENT REGULATION

2.1 ADSS has been consistent in its support for more effective regulatory frameworks at reasonable cost to reflect changes in both the supply and purchasing of independent health and social care. The 1998 Social Services White Paper [7] confirmed the Government’s intentions on the regulation of care and included the proposals for:

- The transfer of responsibility for regulation of nursing and care homes from health and social services to eight regional Commissions for Care Standards [England] with additional responsibilities for areas such as domiciliary care.
- The development of National Required Standards, applying to both nursing and care homes. An immediate revision of the unsatisfactory framework of the Registered Homes Act, 1984, however, is not proposed. There will be a continuation of “dual registration” rather than a single regulatory framework.
- The introduction of “regulation” under “contracting” processes for domiciliary care, rather than a statutory scheme. Day care and other settings will remain unregulated for the time being.
- A commitment to review regulation of independent acute sector hospitals currently covered under Part Two of the Registered Homes Act, 1984 and the future regulation of nurses agencies under the Nurses Agencies Act, 1957.
- Further work to improve the operation of complaints procedures.

2.2 ADSS supports the Government view that the present systems lacks coherence and consistency. We recognise that issues surrounding a “perceived” lack of independence of health and local authority inspection needed to be resolved. The Government has accepted the conclusions of the “Better Regulation Task Force” review of long term care regulation [8] and its plans are framed with the principles of good regulation

[transparency, accountability, targeting, consistency and proportionality] in mind. This is supported by ADSS.

2.3 Whilst appreciating the pressure on legislative time, we believe the Government’s objectives are more likely to be achieved by the creation of a new framework as suggested by ADSS in its response to the Burgner Review [9]. Such a new framework is needed to:

- provide more appropriate regulatory arrangements for acute hospitals and clinics currently registered as “nursing homes” under Section 21 of the Registered Homes Act, 1984;
- respond to the development of “intermediate” care crossing traditional boundaries between acute, nursing and social care;
- reflect expansion of independent healthcare in nursing homes; and
- remove the increasingly false distinction between residential care and nursing homes.

2.4 Regulation is one of the joint national priorities for health and social services [10]. In 1998 the government took action to introduce “open reporting” for nursing homes to bring them into line with the arrangements for care homes [11]. This is to be welcomed.

2.5 Existing inspection staff are a key resource for the future and the changes they face are considerable. The early publication of a timetable for implementing change would help reduce the scope for uncertainty amongst regulators and those subject to regulation. A coherent transition plan, making use of the scope for progress within existing legislative frameworks, also has much to commend it. Careful consideration should be given to opportunities, if they arise, for trialing new national standards; forming interim joint units; or, joint training as part of the transition to new Regional Commissions.

3. NURSES AGENCIES ACT 1957

3.1 Nursing agencies in England and Wales are subject to registration and inspection by local and health authorities under the Nurses Agencies Act, 1957 and subsequent regulations. These arrangements replaced earlier legislation. Standard guidelines for use by local authorities have been produced by LACOTS. [12]

3.2 In 1997 just over 550 registered agencies in England and Wales were listed in Laing’s Review of Private Healthcare Markets (p B103–B116). Around 40 per cent of these agencies were run by five providers operating on a national basis. One provider accounted for 20 per cent of agencies listed. The remainder of agencies appear to operate on a local or regional basis. The distribution was as follows:

Table One
REGISTERED NURSING AGENCIES, 1997

<i>Region</i>	<i>Number of Agencies</i>
London & SE	289
East Anglia	21
East & West Midlands	17
North West	39
Yorks & Humberside	40
Northern	20
South West	55
Sub Total England	[537]
Wales	16

3.3 Whilst there are links with health and social care regulation, in most cases this function tends to be linked to other local authority licensing responsibilities. The focus of regulatory activity is on the licensing of the agency and associated recruitment and selection processes for agency workers. Whilst these are important safeguards, the monitoring of practice is equally essential. This aspect receives little emphasis along with the need for professional supervision and development of nurses working for agencies.

3.4 The Government confirmed in the Social Services White Paper [paragraph 4.44 that it is to review the future arrangements for the regulation of nursing agencies. An information collection exercise commenced in October 1998.

3.5 Most of the work of nurses agencies appears to be concerned with provision of temporary nursing staffs to nursing homes and the NHS. We are concerned it could be argued, as a result, that such agencies do not differ from other employment agencies and might be regulated on this basis.

3.6 Some operators, however, provide nursing homes and many agencies supply nurses for care of private individuals. This suggests that future arrangements for regulation of nurses agencies should be integrated with those for nursing home and domiciliary care. This would be consistent with our view that boundaries

between nursing and social care will become less clear in the future and increasingly dependent and vulnerable people are likely to be cared for at home and in larger numbers than in the past.

3.7 ADSS would prefer a statutory scheme of regulation similar to its proposals for regulation of domiciliary care. The regulation of nursing agencies, therefore, should transfer to Regional Commissions for Care Standards. Such an arrangement would be consistent with the fact that many local agencies are provided through national and regional operators. It could also reduce the regulatory burden.

4. REGISTERED HOMES ACT, 1984: NURSING HOMES

4.1 The continued distinction between nursing homes and care homes raises a number of issues for the regulation of independent healthcare. We remain to be convinced that the Government approach of developing National Required Standards for both nursing homes and care homes and continued reliance on dual registration of care homes is the most robust framework for the longer term.

4.2 Jointly agreed standards are applied already by many health and local authorities. Some are operated by existing joint inspection units. We accept the development of open reporting for nursing homes [11] and the setting up of Regional Commissions for Care Standards will remove some of the complications arising from dual registration of homes as both nursing and care homes. The issue remains, however, as the Social Services White Paper recognises, of whether the future arrangements will ensure sufficient flexibility and adaptability.

4.3 Department of Health statistics confirm the steady increase in the amount of dually registered provision. [13] In 1994 there were 745 dually registered homes of which 667 were for older people. In 1998 there were 2,109 such homes of which 1,799 were for older people.

4.4 Between 1993–94 and 1997–98 there was an annual increase of 3 per cent in the number of nursing homes in England resulting in a 4 per cent increase in beds. Whilst growth rates varied across regions all areas have experienced an increase during the period. Major providers account for 37 per cent of nursing home places in the UK and have doubled their market share in under 10 years [14].

4.5 These trends seem likely to continue. The bulk of nursing home provision is used by increasingly dependent older people. Their numbers will increase. Recent debate surrounding draft National Required Standards for this group has highlighted the presence of inadequate physical facilities and a need for more consistent minimum standards across the country. There are also emerging issues surrounding the supply of nurses and the role of the nursing home sector for their continuing education and professional training.

4.6 The introduction of new National Required Standards for nursing homes and integrated regulation would offer the opportunity to phase out physically substandard accommodation. This could be achieved over a period of time to be defined by Government. Although there may be some local supply side issues to be faced, such a change need not result in market instability or a shortfall in places.

4.7 Nationally, there is continuing under-occupancy of nursing homes and rising expectations for publicly funded places. There would also appear to be over provision in the private acute sector. These factors, along with emerging shifts towards intermediate healthcare, may offer an opportunity, through appropriate use of regulatory processes, to facilitate a market transition. This has started to happen with the entry of major providers and may be inevitable if future care needs are to be met in the most appropriate care setting.

4.8 We recognise these are major issues and are a source of concern to some providers. It is, however, an opportunity for more consistent regulation and a meeting of expectations of purchasers and patients.

5. EVENHANDEDNESS IN REGULATION

5.1 Perceptions surrounding the “evenhanded” application of social care regulatory functions have been a major aspect of the debate about its future. A particular concern has been that direct local authority provision of residential care was not covered by regulation. In future direct provision will be regulated on the same basis as the independent sector. This raises the question of whether or not the same principle should be applied to the limited nursing home and long stay accommodation that continues to exist within the NHS. This is unregulated, although monitoring has been undertaken by the Health Advisory Service and, of course, through Community Health Councils.

5.2 The Government’s acceptance of the principles set out by the Better Regulation Task Force suggest there is a case for applying the concept of “evenhandedness” to current limited NHS direct provision of long-term care and nursing home care. This would ensure common standards would be applied in future irrespective of who provides the healthcare service used by the patient.

5.3 If this point is accepted, we believe future regulation of such NHS long-term care provision should be the responsibility of the Regional Commissions for Care Standards. The National Required Standards should be applied and re-provision of remaining ward accommodation should be considered as an early priority for the NHS.

6. RESOURCING, LOCAL ACCOUNTABILITY AND INVOLVEMENT

6.1 Whilst local authority inspection reports have been published since 1994 [15] similar requirements in respect of Health Authority inspection reports on nursing homes did not come into force until April 1998. [11] This change will help in the production of joint reports on dually registered homes. In some areas it has encouraged the provision of a joint inspection service on an interim basis.

6.2 In January, 1998, Department of Health indicated that the introduction of lay assessors and advisory panels might also be an option for the future. The subsequent Circular [11] and the Social Services White Paper [7] were silent on these points.

6.3 The creation of management boards for the new Commissions for Care Standards could be argued to reduce the need for local advisory panels since they ensure the involvement of relevant key players. The new Regional Commissions, however, will cover large geographic areas. ADSS believes there is continuing value in having fora for local consultation involving local people and stakeholders in the regulation of both care and nursing provision.

6.4 Local authorities have successfully developed schemes of lay involvement in social care inspection processes. ADSS supports lay assessor involvement in both nursing and care home regulation. Such community involvement is of increased importance given the transfer of responsibilities. The thinking in LAC [94] 16 remains equally relevant to regional commissions covering large areas.

6.5 In addition, we believe there may be scope for considering, subject to Government decisions on the future role and resourcing of CHC's, whether there is some value in widening CHC responsibilities in this respect. At present, Community Health Councils do not have a remit to visit or inspect private hospitals or nursing homes except where there are contracted NHS patients. [16] Given the expanded provision of nursing homes and the development of intermediate care involving more contracted patients, a widening of CHC responsibilities may not be inappropriate. [see: section 9]

6.6 Most local authorities make considerable contributions to the costs of regulation of care homes. One study of health authority regulation [17] suggests resource constraints within the NHS may be a factor in determining the intensity of regulatory activity. The adequate resourcing of regulatory functions will be linked to their effectiveness. The stance of ADSS has been a consistent one: public protection and regulation of providers involved in the care of dependent and vulnerable people is a legitimate call on public finance.

6.7 However, the recent Social Services White Paper [Cm 4169] states:

“There will be provision for central funding to be granted to the CCSs, but this will not normally need to be used as they will be self financing through fee income paid by regulated providers. Fee levels will be set by central government for all regulated services.” [paragraph 4.15]

6.8 We believe public funding will be needed. Unless the Government is prepared to increase fees significantly and allow supplementary funding to pursue matters through Tribunals, the new regional commissions risk being under-resourced. This would not be helpful in terms of establishing the standing of the Commissions, or in the interests of providers and users of regulated healthcare provision.

6.9 The transition to new arrangements will also require a replacement of existing guidance [18]. Much of this has been in place for many years and some [eg HSG(95)41] matches guidance to local councils.

7. REGULATION OF PRIVATE HOSPITALS

7.1 The majority of independent hospital and clinic activity relates to acute medical/surgical inpatient and out patient work. The Government has indicated a wish to review the application of Part Two of the Registered Homes Act 1984 to such provision. To some extent separate guidance already exists [19] and a more formal separation would appear to be consistent with the different nature of the functions being regulated.

7.2 Independent sector acute hospital and other private clinic provision has expanded considerably since 1984. For all practical purposes since the Health Services Act 1980, the development of independent sector hospitals has been regulated by local authority planning processes. Few schemes appear to require the consent of the Secretary of State although registration of such facilities is required through health authorities.

7.3 As stated, current guidelines recognise that the 1984 Act covers a wide range of settings and makes separate provision for acute hospitals. The Regulatory process still tends to focus on three aspects: the suitability of the provider, premises, facilities and care given. All are important but it may be felt that within acute care high clinical standards are critical.

7.4 The New NHS White Paper made provision for a National Institute for Clinical Excellence with scope, in time, for expanding its role [para 7.12]. The extension of the remit of the National Institute to embrace independent acute hospitals might usefully be explored.

7.5 This could be used to promote quality standards applicable to all patients irrespective of the sector of healthcare used.

7.6 The independent sector also provides acute psychiatric care and substance abuse clinics and support. Major providers account for the majority of provision. Both specialist sectors have grown since the 1984 Act. Present guidelines for registration should be reviewed.

8. THE DEVELOPMENT OF INTERMEDIATE CARE

8.1 Future regulation should reflect the growth of “intermediate care”[20]. This form of care is substitutional and rehabilitative and may go across current distinctions between “acute hospital” and “nursing home” care. Intermediate care is likely to expand as part of “systems wide” approaches to “Winter Pressures” and management of emergency medical admissions. Much of this care is likely to be jointly commissioned and provided by a mix of NHS, social services, independent health and social care providers.

8.2 Commissioning requirements are not, for us, an effective alternative to regulation. Present regulatory arrangements risk inhibiting system flexibility and may restrict ability to offer improved choice and best value for users and carers. Existing regulatory arrangements should be developed to ensure appropriate standards are available for intermediate healthcare provision. This form of care may involve integrated working across the health and social care professions and has implications for current frameworks for professional regulation.

8.3 New partnerships for community health and social care seem likely to involve new arrangements for care which may or may not be covered by existing and future regulation. Older people are likely to be the major users of such provision. Their vulnerability and dependency should be reflected in the future frameworks adopted.

9. STRENGTHENING COMPLAINTS PROCESSES

9.1 The Government confirmed, in the Social Services White Paper, that it will review complaints processes [para 4.56]. There is confusion amongst users and providers concerning access to complaints procedures. A number of avenues can be used if concerns arise.

9.2 Under Regulation 17[1] of the Residential Care Homes Regulations of 1984 care home providers are required to inform every resident in writing of the way in which complaints may be made. All such complaints have to be recorded and the resident advised of the outcome. Residents must also be advised, under regulation 17[2], of the name and address of the registration authority to which complaints may be made.

9.3 Corresponding provision does not exist under the current regulations for nursing homes and mental nursing homes. Even so, some health authorities have incorporated good practice guidelines within their local standards to match to those in place for residential homes. Formal guidance for consideration of complaints in respect of registered healthcare, however, remain as set out in advice to health authorities. This confirms:

- the responsibility of providers to respond to and resolve complaints; and,
- registration authority responsibility is limited to ensuring there has been no breach of registration requirements; but
- patients placed by health authorities are entitled to have their complaints considered under Health Authority procedures.

9.4 Where services are contracted by health or social services it is also possible to take complaints to the relevant “ombudsman”. The position becomes rather more complicated when jointly provided or commissioned provision is involved. Receiving direct complaints and responses by providers to complaints are important aspects of both regulatory and commissioning responsibilities. The general approach of ADSS was set out in a paper submitted to the Health Committee in April 1998. [Appendix A] The recommendation of the Health Committee in its recent report[21] is supported.¹

9.5 ADSS would like similar and simpler complaints processes to cover registered health and social care provision. Changes should be linked to the setting up of Regional Commissions and reflect the care purchasing levels of local and health authorities within domiciliary, nursing intermediate and continuing healthcare settings.

9.6 Raising and pursuing a complaint in respect of registered provision is seldom easy. There needs to be greater awareness of the existence of complaints processes and support for those who wish to pursue concerns. A recent Office of Fair Trading Report confirmed this. It recommended the provision of improved support and advice and prominent display of information on how to complain.[22] The ADSS response [in preparation] supports both these recommendations.

9.7 The ability of CHC’s to act as a source of information to patients and their supporters and to take on complaints in respect of continuing health care provided directly or through the independent sector has much to commend it. At present, however, complaints received by Community Health Councils from non-NHS patients in registered homes have to be referred to the relevant registration authority.

¹Appendices not printed. See First Report, session 1998–99 Vol II, pp378–9.

9.8 There is also scope for considering wider use of independent persons within complaints processes. This would be consistent with the increased dependency of patients. The pursuit of complaints about unprofessional conduct, however, should continue to be pursued through the relevant professional bodies for doctors and nurses as well as internal complaints procedures where appropriate.

10. THE IMPORTANCE OF EFFECTIVE HEALTHCARE REGULATION

10.1 This submission has concentrated on those aspects of private and independent healthcare having a particular impact on social services as a commissioner of nursing care for vulnerable people. We have also drawn upon our experience as regulators of care homes and the operation of joint regulatory procedures with local NHS partners.

10.2 Other regulatory requirements applying to registered healthcare provision, for example, include: Fire, Food Hygiene [General Regulations] 1970, Food Safety Act, 1990, Health and Safety at Work Act 1974 and the Data Protection Act, 1998. The Government has confirmed the importance of the management of the interface with other regulatory bodies. We agree. Providers and patients are entitled to expect regulators will co-ordinate the exercise of their responsibilities. New Regional Commissions for Care Standards should ensure early development of relationships and protocols with other regulatory bodies operating, in the main, at a more local level.

10.3 There are also other aspects of independent health care which need to be covered by effective regulation such as, for example, long-term care insurance [23], and private medical insurance. These aspects can and do give rise to complaints.

10.4 Whilst they appear to fall outside the present inquiry, it should be noted that problems surrounding such matters can impact greatly upon users of regulated care provision. In this sense the clarity of regulatory relationships may be of some importance to patients and their supporters should difficulties arise with a care provider or purchaser. The report of the Royal Commission on Long-Term Care is likely to have a major impact on thinking surrounding future provision of these services.

10.5 The maintenance of effective healthcare regulation will also depend upon the skills and continuity of inspection staff. The new Commissions for Care Standards will have their own staff although not all of them may be permanent staff. Approaches to human resource management and possible skill shortages will be critical. The Social Services White Paper confirms decisions remain to be made on how staff will be deployed, although the importance of training is recognised in terms of consistency and effectiveness [Cm 4169, paras 4.16-4.18].

10.6 The present arrangements have weaknesses and many aspects of the system are about to undergo significant change. There is the prospect of further changes when Government reviews of Complaints, Acute Sector and Nurses Agency Regulation are completed. Bringing the various standards together can only be helpful.

10.7 ADSS believes the protection and promotion of the welfare of vulnerable people who use regulated independent healthcare services is a priority consideration within the framework of better regulation which is emerging. The public expects that appropriate standards and checks will be in place to ensure satisfactory care. Regulation needs to reflect the changes in provision in recent years; the likelihood these trends will continue; and, to ensure there are simple and effective arrangements for the handling of complaints. The Health Committee's inquiry is very timely.

11. REFERENCES

- [1] Laing & Buisson, Laing's Healthcare Market Review, 11 Edn Sept 1998. London, 1998.
- [2] Department of Health, The New NHS modern, dependable [Cm 3807] HMSO, December 1997.
- [3] Department of Health, Modernising Mental Health Services, safe sound and supportive, HMSO, Dec 1998.
- [4] Laing & Buisson, 1998, Table 6.2.
- [5] Department of Health, Partnership in Action, September, 1998.
- [6] Department of Health, Emergency Services Action Team, 1998 Report, NHSE, August, 1998.
- [7] Department of Health, Modernising Social Services, promoting independence, improving protection, raising standards [Cm 4169], HMSO November 1998 [Chapter 4].
- [8] Better Regulation Task Force, Review of Long-Term Care, May 1998.
- [9] The Regulation and Inspection of Social Services, Department of Health, 1996. [Burgner Report].
- [10] Department of Health, Modernising Health and Social Services, National Priorities Guidance, 1999-2000-2001-02, September, 1998, [p14].
- [11] Department of Health HSC 1998/047 & LASSL [98] 4.

- [12] LACOTS [Local Authorities Co-ordinating Body on Food and Trading Standards], Licensing of Nursing Agencies, December 1995.
- [13] Department of Health, Statistical Bulletin Community Care Statistics, December 1998, Table R1.
- [14] Laing & Buisson, 1998, Table 6.17.
- [15] Department of Health. LAC [94] 16, April 1994.
- [16] National Association of Health Authorities [Now NHS Confederation] Registration and Inspection of Nursing Homes, A handbook for Health Authorities, 1985. p34.
- [17] West Midlands Health Research Unit, A Survey of West Midlands Inspectorates, November 1996.
- [18] Department of Health Circulars: HC[81]8, HC[84]21, NAHAT Nursing Home Care for Terminally Ill People, NAHAT, Raising the Standard, 1995, NAHAT supplement and Audit Workbook, 1998.
- [19] NAHA, 1985, p122-134; Nursing Homes [Lasers] Regulations, 1984.
- [20] Steiner, Andrea, Intermediate Care, Kings Fund, 1997.
- [21] House of Commons Health Committee, First Report, Session 1998-99, The relationship between health and social services, December, 1998. pxix
- [22] Office of Fair Trading, Older People as consumers in Care Homes, October, 1998.
- [23] House of Commons, Health Committee, Third report Session 1995-96, Long-Term Care: Future Provision and Funding, Vol 1, plxii-lxiii.

APPENDIX 28

Memorandum by The Relatives Association (PM 63)

1. The Relatives Association is a UK wide charity which focuses on the well being of older people in Homes and Long Stay Hospitals. It was founded by the relative of someone in a Home and is based on the recognition that many relatives and friends remain anxious to be involved in the care of residents, to support and advocate for them. Also that the perspectives of people who visit Homes regularly are important in safeguarding an adequate standard of care *viz* they are the "eyes and ears" in every Home. Collectively their experiences should be fed into policy making.

2. Many of the frailest citizens live in Homes, indeed 18 per cent of the population now die in Homes. This is a relatively new situation. Homes having now largely taken over from Long Stay Hospitals.

Residents do not choose to be outside the NHS, as they do if they opt for private hospitals. The system has simply been changed so that the majority of continuing care is no longer provided by the state.

3. Systems for inspection of health services in Homes have not been adapted to meet the changed circumstances. Homes are inspected by Local Authority or Health Authority based services but this does not adequately cover clinical care. It would be desirable to cover all the separate dimensions of clinical care eg, adequacy of palliative care, rehabilitative care, an overview of amount of medication used, the Homes relationship health providers (GPs, Community nurses, Hospitals etc). In effect, the whole standard of clinical care.

4. One particular important element to include in the near future will be the effect that the Primary Health Groups are having on health care for older people in Homes. It is possible that additional problems may arise by directing funding and attention away from the high care needs of the very frail and adversely affecting the quality of medical care in some Homes.

5. One method of inspecting and monitoring health care in Homes within the Inspection framework would be provided by the Social Services White Paper. The eight area Inspection and Regulatory Authorities could perhaps include medical staff and dentistry and other professions allied with medicine in addition to the planned nursing and social care professionals. Spot checks and inspection by these medical professionals could ensure that clinical standards were safeguarded in Homes.

6. We know that much general good practice has been spread by Inspectors. A similar advancement on the clinical side could be a benefit from clinical inspections, over and above ensuring the safety of residents.

7. An additional dimension is that such clinical monitoring could be a route for sustaining and developing knowledge about the long-term medical care of older people. Now older people are away from the Gerontological specialists in the Hospitals there is a real danger that medical knowledge about older people's care will cease to develop and may even be lost.

8. If a system for monitoring medical care in homes is established another additional value is that the findings could be collected. They would provide a light in a very dark area. At present little is known about standards of medical care in Homes, and the relationship with the NHS. With more knowledge and higher universal standards new options may become available including better rehabilitation, and perhaps treatment of some acute episodes in the Homes instead of transferring people to Hospitals.

APPENDIX 29

Memorandum by the Chartered Society of Physiotherapy (PM 64)

The Chartered Society of Physiotherapy (CSP) would like to assist the Committee's Inquiry by presenting its evidence in two sections:

Section One—The CSP's perspective on professional self-regulation and the issue of protection of title.

Section Two—Evidence from the Organisation of Chartered Physiotherapists in Private Practice.

SECTION ONE —CHARTERED SOCIETY OF PHYSIOTHERAPY VIEW ON PROFESSIONAL SELF REGULATION AND PROTECTION OF THE PUBLIC

1.1 The Chartered Society of Physiotherapists represents 35,000 chartered physiotherapists, physiotherapy assistants and students. The society estimates its membership includes 98 per cent of state registered physiotherapists. A growing proportion of the Society's members work in the independent healthcare sector. Eleven per cent work in their own independent practices, and a further four per cent work in independent hospitals. Many thousands of other physiotherapists are employed both in the NHS and in the independent sector.

1.2 The society supports three special interest groups whose members work predominantly in the independent sector: The Organisation of Chartered Physiotherapists in Private Practice (OCPPP), the Association of Chartered Physiotherapists in Independent Hospitals, and the Association of Chartered Physiotherapists in Occupational Health. Their views have been sought in drawing up this response. The OCPPP is the largest of the three groups and has drawn up its own comprehensive response to the Committee's Inquiry (see Section Two).

1.3 The groups share many issues in common, the most important of which relates to the absence of protection of the titles "physiotherapist" or "physical therapist". However, there is a lack of uniformity in systems associated with maintaining clinical excellence, such as audit schemes. While the OCPPP offers an accreditation scheme for members which includes audit elements, attempts to introduce clinical audit into the independent hospitals sector has met with less success. Physiotherapists working in this area are concerned to persuade employers of the value of such measures.

1.4 As the professional body for the UK's physiotherapists, the CSP sets and monitors professional standards, identifies and enforces rules of professional conduct. The CSP monitors and recognises degree courses in physiotherapy provided within university departments in the UK. Without membership of the CSP a physiotherapist cannot claim chartered status.

1.5 The Society remains concerned at the lack of progress on the proposed revision of the Council for Professions Supplementary to Medicine (CPSM). The Act governing the CPSM is now almost 40 years old and the real concerns the Society has been expressing for some time regarding the out of date disciplinary and conduct process still apply. It is our view that the Bill to enact the legislative changes outlined in the NHS White Papers, could easily incorporate clauses to revise the PSM Act, based on the existing draft legislation. Also, the fact that State Registration is only required for work in the NHS is an anomaly with an increasing number of physiotherapists practising in the independent sector. This means that with no protection of title in the private sector, the public are at risk from practitioners working outside any regulatory framework including those administered by the State or professional body.

1.6 The lack of protection of title not only applies to those "physiotherapists" ineligible for MCSP or SRP. In a case where serious allegations of indecent assault brought against a chartered and state registered physiotherapist resulted in their name being removed from both the CSP and the State Register, the physiotherapist has not ceased practising. This provides, therefore, a potential danger to the public and, whilst the current systems are open and accountable, government inaction has allowed this to occur.

1.7 Quite simply the Society believes the current law is inadequate. In the interests of public protection it is not acceptable that those unfit to treat patients—either because they have no clinical qualification, or because they have been struck off the State Register and had their chartered status withdrawn for serious disciplinary offences—can, legally, openly advertise their services as "physiotherapists" as part of a private business. Draft reforms of the 1960 PSM Act include measures to stop these abuses by instigating protection of title. The Society urges the Committee to recommend the urgent implementation of reforms to protect the public by reforming the 1960 PSM Act.

1.8 We therefore welcome the statement in paragraph 3.47 of *A First Class Service*, "the challenge now is for the Government and clinical professions to work together to modernise that framework so that it is fit for the next century".

1.9 The Society recognises and endorses the view that any system of self-regulation must be open, responsive and publicly accountable and put the protection of the public as a primary concern.

1.10 To this end, the Society is currently re-organising its system of responding to complaints about chartered physiotherapists. A new Regulatory Committee will be in place in September 1999, which will put at arms length from the governing Council the operational responsibility for the Society's work relating to

professional conduct cases and its expected future work relating to the appropriate monitoring of qualified members' CPD. It is also proposed to strengthen the Committee by ensuring that 25 per cent (six of 24) of its membership is lay. We currently use our lay co-opted members on both our Preliminary and Professional Conduct Committees, but we wish to increase the percentage considerably.

1.11 The Society, through its Rules of Professional Conduct, Standards of Physiotherapy Practice, Clinical Effectiveness Strategy, CPD and lifelong learning initiatives and Professional Practice Disciplinary Rules, all of which are in the public domain, demonstrates the transparency and accountability to the general public.

SECTION TWO—EVIDENCE FROM THE ORGANISATION OF CHARTERED PHYSIOTHERAPISTS IN PRIVATE PRACTICE (OCPPP)

The points covered in our response are:

- the extent of healthcare provided by our group in this sector;
- current schemes/procedures for ensuring quality in clinical practice;
- views on the extension of new NHS systems to ensure clinical quality to independent sector eg NICE, Clinical Governance;
- wish list for how we would like our sector regulated/monitored.

THE EXTENT OF HEALTHCARE PROVIDED IN THIS SECTOR

2.1 The Organisation of Chartered Physiotherapists in Private Practice is the Occupational Group of the CSP formally recognised by the Council of the CSP as representing the interests of its self-employed members. The OCPPP also has a trading name: PhysioFirst.

2.2 The objectives of the OCPPP include:

1. The promotion of the highest standards of clinical practice in physiotherapy generally and specifically in independent practice.
2. The promotion of the interchange of professional skills and ideas between individual practitioners.
3. The encouragement of the Continuing Professional Development (CPD) of all members ensuring that all members participate in a recognised level of CPD annually.
4. The encouragement of the highest standards of professional practice management in independent practice.

2.3 The organisation is administered on a regional basis. It is supported by a membership database which identifies where physiotherapists are located, the expertise of the physiotherapists and what clinical service is provided at that location. This database is updated continually. A directory of members is published annually and identifies the location of the membership of OCPPP.

MEMBERSHIP

2.4 OCPPP currently has 2,900 members—all are Chartered and State Registered Physiotherapists. This ensures that they all carry appropriate levels of professional and public liability insurance and that the public are protected by the rules and procedures of the CPSM and CSP. The current membership numbers of OCPPP represent over 10 per cent of the national resource of physiotherapists.

EMPLOYMENT STATUS

2.5 The majority of OCPPP members are self-employed. Independent Chartered Physiotherapists are responsible for all aspects of the delivery and management of their physiotherapy service within the community. They provide premises, staff, and equipment and are already integrated into the primary care networks.

2.6 Independent self-employed Chartered Physiotherapists are also responsible for their own pension provision and post graduate education.

THE PHYSIOTHERAPY SERVICE

2.7 OCPPP members have provided independent physiotherapy services within primary care for 50 years. These services can be:

- as a private service where the patient, medical insurance company or workplace scheme bears the cost;
- as independent contractors to the NHS—similar to independent contractor status of GPs—providing services to GPs for their NHS patients which are free at the point of delivery;

- independent Chartered Physiotherapists are based in the community—in clinics, in the workplace, nursing homes, schools, sports centres, and GP practices, treating acute and chronic problems. They provide domiciliary services directly to patients facilitating the management of long term disability in the home;
- The NHSE has identified the independent physiotherapy resource as part of the total national physiotherapy resource. OCPPP members have been originally trained by NHS and if not fully utilised, will be lost as part of a potential NHS resource;
- The numbers of independent Chartered Physiotherapist members of OCPPP represent the ability to treat 30,000 patients a day and currently provide over 7.5 million treatment sessions a year.

CURRENT PROCEDURES FOR ENSURING QUALITY

2.8 OCPPP is actively promoting Best Practice to members through:

- Standards for Independent Practice;
- Mandatory CPD;
- Practice Accreditation;
- Satisfaction Surveys;
- Outcome measurement and analysis activity;
- International sharing of information—OCPPP is a founder member of an international group of independent practitioners. The International Private Practitioners Association (IPPA) is an official sub-group of the World Confederation of Physical Therapy which already shares clinical information and management information concerning best practice in the delivery of healthcare.

STANDARDS FOR INDEPENDENT PRACTICE

2.9 OCPPP has developed Standards for Independent Practice which are additional to the Chartered Society's Standards for Physiotherapy Practice and to the Clinical Standards developed by the CSP's Clinical Interest Groups. These Standards relate to the overall management of an independent physiotherapy service. These Standards are regularly reviewed.

MANDATORY CPD

2.10 OCPPP introduced a mandatory Continuing Professional Development Scheme in 1996. It recognised the importance of CPD for physiotherapists who often work alone. The CPD scheme requires its members to undertake at least 25 hours CPD annually or 50 hours in a two year period. This system is monitored and is the first stage in a five year plan for the development of a reflective and evaluative system of continuing professional development.

PRACTICE ACCREDITATION

2.11 OCPPP has recognised that its members are responsible for all areas of the service delivery. This includes clinical services and the management of that service. Five years ago OCPPP developed a Practice Accreditation scheme for independent practices. This was developed after research into existing schemes both within healthcare and outside it. The scheme is regularly benchmarked against other quality systems in the marketplace and against the needs of the healthcare marketplace itself. This should ensure that it always reflects the evolution of health provision.

2.12 The issues addressed within the Practice Accreditation scheme are:

2.13 *Practice Organisation and Management*—Good business management is essential to the long-term success of the practice and therefore to the delivery of a quality service. The practice's organisation and management procedures must, as a minimum, demonstrate clarity of purpose and control of all activities.

2.14 *Premises and Equipment*—The quality of the service provided for patients is affected by the nature of the facilities and equipment available at the practice. The practice must demonstrate that it offers a clean, safe and comfortable environment for patients, staff and other visitors to the premises.

2.15 *Operating Procedures*—Robust practice management systems are essential to facilitate the delivery of a quality service to patients. The practice must demonstrate, through its policies and procedures, that its activities are supported by efficient and effective systems. Evidence must be provided that such policies and procedures are in place.

2.16 *Personnel*—The Practice's personnel are essential to the provision of a quality service to patients and other organisations. The practice must ensure that each member of the practice is clear about their role and is appropriately trained to carry it out. The practice must also demonstrate its commitment to continuous quality improvement through the ongoing training and development of its staff.

2.17 *Patients and Other Organisations' Expectations*—Patients and other organisations are entitled to receive a quality service from the practice. The practice must demonstrate that it understands and caters for the needs of individual patients and other organisations.

2.18 *Audit and Quality Management*—The practice's long term business and professional success depends on the maintenance of a high quality service for patients. The practice must demonstrate that it employs a constant questioning approach to all its activities, thereby seeking to continually improve the quality of service it provides to patients. This effort must be facilitated by a systematic Annual Review as well as the practice's procedures. The Review must monitor and evaluate the practice's performance in all areas and lead to the correction of areas of non-conformance and the enhancement of quality as opportunities arise.

2.19 *Satisfaction Surveys*—OCPPP members undertake Patient Satisfaction surveys as part of the Practice Accreditation scheme to ensure that the views of patients are understood and incorporated into the delivery of the service.

2.20 *Outcome Measurement and Analysis Activity*—The clinical audit and the measurement of the outcomes of practice is an integral part of the Practice Accreditation scheme. Analysis of the results provides a focus for CPD planning and for the development of a best practice approach to clinical practice.

FACTORS WHICH INFLUENCE QUALITY IN THE INDEPENDENT SECTOR

2.21 Experienced post-graduate physiotherapists bring the experience necessary for delivering a broad range of accessible services which are based on the needs of the community.

2.22 Quality of outcome can be determined by the length of waiting time to access physiotherapy services—up to six months in some NHS Regions. The average length of waiting time in the private sector is 48 hours, with most practices offering appointments within 24 hours. Out of hours appointments are also available within most practices.

2.23 The average length of treatment time allocated to a patient in independent practice is 35 minutes. The length of time together with a one-to-one approach to treatment, allows for in depth assessment of the problem, adequate treatment time and time for educational activities which help to prevent recurrence and encourage self-management. Consequently, fewer treatment sessions are required to achieve a satisfactory outcome, thus ensuring that cost effectiveness is also achieved.

2.24 Well established communication with GPs within the primary care setting and local consultants, ensures that the best interest of the patient are served at all times.

2.25 Well established communication network within the Organisation. OCPPP produces a quarterly journal—called *In Touch*. It also produces a newsletter as frequently as required to keep members up to date with matters of health and safety, legal issues, Government health strategy and all relevant issues.

2.26 Independent chartered physiotherapists who have held contracts with fundholding GPs have formally defined the quality of their service provision within the current contracts.

2.27 OCPPP supports and encourages the professional development of its members through the organisation of regional clinical and management courses for members which can be accessed readily by independent practitioners. It also organises an annual conference which keeps members up to date with the development in clinical practice, practice management, information technology, medico-legal issues etc.

2.28 With regard to the extension of new NHS systems to ensure clinical quality to independent sector eg NICE, Clinical Governance. In the context of a national shortage of chartered physiotherapists, it is essential that such an important source as exists in the independent sector, is fully utilised to deliver the necessary healthcare to the population as a whole. We therefore feel that the changes currently underway within the NHS are relevant to all health professionals. We also feel that all health professionals must also be actively involved in the consultative process which will occur when developing national standards of care, Health Improvement Programmes, National Service Frameworks or targets for health provision.

2.29 Best practice within the independent sector must be integrated into the whole picture when developing clinical guidelines or service frameworks. If this does not occur, there will be no feeling of "ownership" of health standards by the independent sector.

2.30 There must be "two-way" pathways for sharing best practice between public and private medicine.

HOW OCPPP WOULD LIKE THE SECTOR REGULATED/MONITORED

2.31 OCPPP feels that it has been very pro-active in regulating its members. We are constantly seeking to understand the marketplace and the needs of patients and purchasers.

2.32 We therefore feel that there is adequate regulation through:

- The CPSM—Rules and Disciplinary procedures;
- The CSP's Rules of Professional Conduct and soon to be strengthened disciplinary procedures;
- The CSP's Standards for Physiotherapy Practice;

- The Standards for Clinical Practice;
- Clinical Guidelines;
- OCPPP Standards for Independent Practice;
- OCPPP Mandatory CPD;
- OCPPP Practice Accreditation Scheme.

APPENDIX 30

Memorandum by Mr A Darley-Jones (PM 65)

Summary of events: My wife, Christine, was admitted to the private hospital, St Anthony's Hospital, Cheam, as a day patient on 22 March 1994, for the investigation under general anaesthetic of her recent worsening cough. Whilst being anaesthetised she went into cardiac arrest—this has been attributed *inter alia* to anaphylactic shock—and when she was eventually fully resuscitated some 40 minutes later, she was found to be massively brain damaged.

After a brain scan at the Atkinson Morley, she was kept at St Anthony's for the next three months. I was given the impression that there was scope for improvement and that her treatment would be free of charge. Her condition did not improve, however, and her insurers, who were in fact funding her care, unbeknown to me, (they paid out £28,000), now withdrew funding. This was taken over by Merton and Sutton Health Authority (now MSW Health) who transferred her to the Royal Hospital for Neuro-Disability in Putney, where she stayed for some two years. She has since been transferred to the British Home and Hospital for the Incurables at Streatham where she has been for nearly three years.

The matter is still being investigated legally, with a view to a possible claim for compensation. After the incident I was advised by the hospital manager that there would be a "full internal and external" investigation of the incident, but I have heard nothing further (although he also said the three staff involved refused to speak to him). Nor was I advised of the hospital's internal complaints procedure, which I later learnt had been in place since October 1991, and no details were given in the patient information literature. Nor was I advised of my right of access to the Health Authority with my complaints if I was dissatisfied with the hospital's response, as set out in 1993 NAHAT guidelines (the Association of Community Health Councils makes mention of this in its submission to the Health Committee).

It wasn't until a year and a half later that I learnt of this avenue of complaint and asked the Health Authority to investigate. I enclose the result of their investigation.¹ I have to say I did not find it the thorough investigation that I was led to expect would take place, especially in the light of the severity of my wife's injury. I expected at the least that the staff involved would be interviewed, as the NAHAT guidelines advocate, but this did not happen.

A year and a half after this investigation (and three years after the incident), following the very thorough re-investigation that Tees Health Authority conducted into another private hospital case (I understand that the patient's husband, Mr Graham Maloney, has forwarded details), I asked MSW Health if they would also re-investigate my wife's tragedy. I pointed out that both incidents had taken place at the same time, and that there were a number of areas indicating possible breaches of the registration requirements. I also considered that the high costs to the Authority of my wife's care—amounting then to a substantial six figure sum—might also provide further incentive: a very thorough authority investigation along Tees HA's lines might uncover new facts which might assist the legal investigation, and a successful ensuing legal action might result in my wife's funding being met by financial compensation from medical insurers.

The Authority initially declined, citing their advisers' view that their duty was only to assess the "fitness" or adequacy of the hospital at the present time. When I questioned that view, the Authority acceded to a further investigation, but only as a "joint review" with St Anthony's. Plans were drawn up for the investigation to involve independent parties, including the Chairman of another Health Authority. However, it was pointed out that St Anthony's would first have to agree to the investigation. When St Anthony's subsequently and perhaps unsurprisingly declined, the Authority advised that the investigation could not now proceed, as a joint review could not be conducted unilaterally. I asked the Authority if they could supply the reasons the hospital gave for not participating in the investigation. The Authority stated that they were not able to supply these as the hospital had not allowed them to do so.

The whole process of asking for this re-investigation lasted over a year, with some 20 letters, and the unsuccessful outcome does, I think, emphasise a lack of consistency in different health authorities' interpretation and application of their regulatory role. I think all health authorities, following Tees HA's precedent, should now conduct investigations along Tees' lines (which in fact are those advocated by NAHAT in 1993). Ultimately, rigorous investigations resulting in recommendations for improvements, may help reduce future untoward incidents and thus cost to the NHS.

The Committee will be aware of another serious untoward incident at this hospital two years before my wife's case (the family are also submitting evidence). When the family approached the Authority a month

¹ Not printed.

after the death they were told to go away. Their subsequent Authority investigation, several years later, led to nearly six pages of recommendations for improvements, and I often wonder whether, had the Authority immediately investigated that case thoroughly, this might have led to a general raising of standards at this hospital which might in turn have prevented my wife's tragedy.

A number of further suggestions I would make are as follows:

1. Complaints procedures. All private hospitals should be subject to a statutory and not voluntary complaints procedure similar to that which operates in the public health sector, with access to an independent review panel and an ombudsman.

This should also be conducted promptly. As an illustration of the delays (perhaps deliberate) under current procedures, it took nearly a year and a half for my solicitors to receive what the hospital claimed was all the documentation. Similarly, the Health Authority's investigation of the other family's complaint, promised in "six to eight weeks", took an unjustified three years (and also with no staff interviewed).

2. Under present legislation, Health Authority inspectors at their twice yearly visits for the most part only evaluate the non-clinical "hotel" aspects of patients' care. They must have the powers to scrutinise the quality of clinical care, including that of consultants.
3. Procedures should not be carried out in hospitals which do not have the facilities or the staffing to cope with any complications which might arise.
4. It should be made a specific offence for a private hospital or a consultant to tamper with medical records, or provide incomplete records, or indeed to place obstacles in the way of an investigation into an untoward incident (eg "losing" contemporaneous notes).
5. Private hospitals should be made liable through their insurers if necessary for mistakes made by consultants who use their premises. In granting them admission rights the hospital is in fact already accepting some responsibility.
6. Ideally, these hospitals should be regulated by a truly independent inspectorate, as advocated by both AVMA and the RCN. The RCN in its 1994 report "An Inspector Calls?" suggests that there may be problems with individual inspectors' judgement being impaired by friendliness with or intimidation from private hospital operators, or when the Authority is also at the same time contracting with the hospital to treat NHS patients. An independent inspectorate might also lessen any possibility of corruption should this ever take place.
7. "Fitness". Under section 25 of the Registered Homes Act, authority inspectors have an ongoing statutory duty to seek to ensure that operators, managers and matrons of private hospitals are not "unfit" to carry on their duties. Failure to respond to complaints and investigate serious untoward incidents could call into question this fitness, and authorities should be made to apply this aspect of their duties more rigorously.
8. Misleading Advertising. Hospitals, and health insurers, should make the public aware in their advertisement that their customers will in fact be contracting with two separate parties. Often the impression is given that one is dealing with a single organisation and it is only when there is an untoward incident that the hospital will suddenly reveal that it has no responsibility for the consultants on its premises; it will then present itself as only in fact a sort of hotel which rents out rooms and operating theatres to consultants.

Similarly, hospitals should not be allowed to advertise their accreditation by the King's Fund or British Standards as implying that these are audits of their clinical care. These are organisational audits, for which they pay, and which involve considerable self-assessment. The public can again be misled.

APPENDIX 31

Letter from the Managing Director Prime Health to the Clerk of the Committee (PM 66)

Prime Health is the UK's fourth largest health insurance company and part of the Standard Life group. We specialise in the provision of private medical insurance offering a range of comprehensive plans and add-on products such as dental, critical illness, personal accident and cash plans. I have enclosed a copy of our corporate brochure for your information.

While we do not own any private hospitals or clinics, we have great interest in the subject of your inquiry and would like to take this opportunity to outline issues for consideration. My current position as managing director of Prime Health, previous position as director of hospitals for BUPA Hospitals and 12 years working within the NHS, enables me to comment with authority on the regulation of private and independent healthcare.

I have outlined in brief those areas which I believe should be considered in your inquiry but would welcome the opportunity to talk about them in more detail if you would find this of benefit.

REGULATION OF HEALTHCARE

We support the call for regulation of healthcare. We believe it is in the interests of all concerned, most importantly the consumer, to put in place an effective system to monitor the operation of and standards of care within hospitals in both public and private sectors. At present there is no assurance that hospitals are applying the same standards and it is our belief that health authorities often apply different standards. We would therefore call for a consistent system across healthcare in the UK.

The Nursing Homes Act which covers private hospitals at the moment is inappropriate. It was introduced in circumstances very different from those which exist today and therefore is in urgent need of an update.

OMBUDSMAN SCHEME

It is important to have an effective complaints procedure in place to protect the consumer. The NHS already has an ombudsman scheme and it would seem sensible to implement a similar system of independent review in the private sector.

However, a separate system would be required for the private sector which mirrors the NHS system, but focuses purely on private medicine. This is because in areas such as service standards and accommodation, the expectations of customers paying for private treatment will be different from those receiving care under the NHS and a separate complaints scheme would, therefore, be necessary in recognition of this.

AUDIT PROCESS

A clinical audit process should be established which reflects agreed minimum standards and this should be common to both public and private sectors.

We would suggest that this includes monitoring of those who practice private medicine; nurses, doctors and consultants. Procedures should be put in place to review clinical competence and a programme for ongoing clinical training, education and professional development should be considered.

CLINICAL STANDARDS

The Government has given its commitment already to achieving standards for clinical excellence through the establishment of the National Institute of Clinical Excellence. In establishing clinical standards in the private sector, it will be important that the same standards are established as those in the NHS.

We agree with the IHA that as there is increasing exchange of facilities between the two sectors, there is a real need for a commonality between the two sectors. Minimum standards set for hospitals operating in the private sector should include 24 hour on-site RMO cover, seven days a week (with appropriate levels of training for treatment being carried out in individual hospitals); facilities to accommodate intensive care treatment and the presence of an on-site specialist in ITU equipment.

This exchange extends to human resources since the vast majority of consultants working in the private sector also work within the NHS and this adds further to the need for common standards.

NATIONAL REGISTER

A national register of private practitioners, including consultants, doctors and nurses should be established. If a practitioner is suspended in the private or the public sector, there should be a way of making the suspension public taking these practitioners off the register so they are not used by private medical insurers or directly by members of the public.

SPECIALIST REGISTER

At present there is no access to information detailing how good a specialist is, what areas surgeons specialise in, morbidity rates, mortality rates or whether any training has been undertaken in the last 12 months. A register of this information should be set up, possibly via the NHS net site, with access levels for GPs wanting to refer patients and requiring more in-depth technical details and another level for patients wanting more general information about their specialist. Again this should be introduced across private and public sectors.

CATEGORISING HOSPITALS

Consideration should be given to different categories of hospital, depending on the type of treatment offered/specialisation eg level one for heart surgery etc. The higher the category the higher the standards of support/facilities available should be within these hospitals. From the consumer perspective, it would then be easy to check that the hospital chosen is in the right category for treatment, ie right support.

APPENDIX 32**Memorandum by Changing Faces (PM 69)****TERMS OF REFERENCE:**

“To examine the adequacy and extent of the regulation, monitoring and inspection of healthcare outside the NHS. The Committee will also take evidence on complaints procedures relating to such provision”.

ABOUT CHANGING FACES

Changing Faces works for a better future for children and adults affected by any form of facial and other disfigurement, whatever its severity or extent. The Charity employs ten professionals in various capacities to “support and represent” children, their families and adults affected by facial and other disfigurements. We aim to boost self-confidence and self-esteem, to advocate excellent health care, and to promote equal opportunities for everyone who has any disfigurement.

WHY ARE WE SUBMITTING EVIDENCE TO THE COMMITTEE?

With the ever-increasing pressures on people to “look good” and the limited resources available for cosmetic surgery within the NHS, the private and independent health care sector in the UK seems to have experienced a considerable increase in demand over the last decade (mirroring with the usual lag the huge growth in the US).

We are concerned that the UK cosmetic surgery industry is failing to provide high-quality, ethical and needs-driven health care and thereby risks emotional distress to large numbers of people. We have no objective statistics to support this observation but are relying on the evidence provided by our clients and staff, and are currently collecting data on the extent and type of psycho-social needs.

We welcome the Committee’s inquiry as it at last recognises the need to improve the public regulation and monitoring of the industry, something which no quality operator should have any anxiety about. We consider that this regulation should include the advertising, pricing, clinical procedures and follow-up arrangements of all cosmetic surgery practices.

UNDERSTANDING DISFIGUREMENT AND APPEARANCE CONCERNS

The reasons why people seek cosmetic surgery or other “appearance-enhancing” treatments are complex. Research suggests that the main reasons are because they perceive that their current appearance is the cause of their low self-esteem or self-confidence. They believe, for example, that if a particular feature (e.g.: nose, ears, wrinkles, jaw) is modified or removed, they will enjoy feelings of youthfulness and with it, (re)gain some additional quality of life.

There is no doubt that unusual appearance and/or disfigurements can cause these psychological and social (psycho-social) effects. Whether the cause is a congenital one, such a birthmark or mole, or from an accident such as scarring, or from a dermatological condition such as acne, or is self-inflicted such as a tattoo, they can all have serious consequences. They may make the affected person self-conscious and this can lead to a withdrawal from social contact, avoidance of public places, problems in first meetings and in making friends, difficulties in forming friendships and relationships, teasing and bullying at school, social isolation and depression.

It is also important to note that our casework and research work confirms a counter-intuitive finding from the academic literature on this subject: the severity of a disfiguring condition does not correlate with how distressing it will be to the person affected. Even what may appear to be a minor mark can have devastating effects on self-esteem. The reason for this appears to be that there is less certainty in the mind of the person affected about whether their scar or feature is noticeable to others than for someone with a “total” facial disfigurement. With the uncertainty goes anxiety and a loss of control.

The important point is that many, perhaps most, of the people seeking changes in appearance from cosmetic surgery have psychological and social needs (psycho-social) to which they are seeking surgical solutions. By and large, they do not have functional problems for which they could receive treatment under the NHS.

WHAT DOES THE COSMETIC SURGERY INDUSTRY OFFER

Changing Faces considers that the cosmetic surgery industry plays on these psycho-social concerns through its aggressive advertising campaigns, many of which show tantalisingly “perfect” bodies with accompanying script full of hyperbole. These promise to rebuild people’s confidence and even change their lives by modifying features or removing the wrinkles etc.

Our evidence suggests that:

- The assessment of patients' psycho-social needs is almost entirely neglected by the cosmetic surgery industry. Such an assessment should be carried out by a psychologically-trained professional alongside the surgical, laboratory and other tests. It is not adequate to have a receptionist or business manager perform such an assessment;

(NB: we are not suggesting that, at present, such psycho-social assessment is routinely done within the NHS but it is now increasingly recognised that it should become so. See, for example, the recent report of the Cleft Implementation Group set up by the Department of Health to reorganise services for cleft lip/palate patients. Multi-disciplinary team-working including the involvement of a psychologist is now seen as a model of good practice).

- Cosmetic surgery is not always appropriate for patients seeking cosmetic surgery. Were thorough psycho-social assessments conducted, it would be clear in many cases that non-surgical forms of intervention might well be more appropriate.

Furthermore, research does not suggest that surgical intervention is the key to coping with appearance or disfigurement problems. Adjustment to these problems is encouraged by the presence of quality social support around the individual affected, by the development of positive beliefs and sturdy communication/social skills. Surgery can have the reverse effect and be detrimental in some cases because it raises false expectations of solutions to complex problems;

- When patients do complain to our staff about their failed surgery, it is usually because they feel that they have been "conned" into surgery without the chance to consider other options. It is tempting, of course, to say that it is not in the interests of the cosmetic surgery clinic either to carry out such psycho-social assessments or to offer a menu of therapeutic options to its customers/patients.
- Patients who seek cosmetic surgery are very rarely offered any psycho-social intervention which might be an alternative to or complement the surgery (such as social skills training or counselling).

In the six years that *Changing Faces* have been in existence, we have received only a tiny handful of requests for information from cosmetic surgery clinics (eg: about our innovative self-help guides or social skills training), compared with thousands of requests from NHS professionals.

- Patients are too often provided with inadequate post-surgery follow-up leaving them confused and unsure (and worried about the financial consequences of seeking further advice).
- Some patients acquire, unrealistic expectations of what can be done—and then find themselves disappointed. This is true in many forms of health care but where expensive cosmetic surgery is involved, patients can feel badly let-down by the poor pre-intervention advice they have received.
- Complaint procedures are invariably tortuous and frustrating. We have seen too many patients who have become extremely depressed by what they perceive is failed surgery compounded by the impossibility of gaining any kind of compensation. It would appear that gaining an independent assessment of negligence is very hard and that the industry's insurance and defence processes conspire to make the taking of complaints as difficult as possible. Without legal aid, in many cases, patients are left to bemoan their misfortune, much of which they wrongly put down to their own fault.

WHAT DO WE RECOMMEND?

On the basis of these observations, we believe it is important and timely for the Government to be encouraged to make a positive effort to regulating the cosmetic surgery industry.

In particular, it should consider:

- Monitoring of clinic facilities, provisions, and staffing (by type of staff, their training etc) possibly with an accreditation process.
- Requirements that multi-disciplinary assessments are made by cosmetic clinics.
- Tighter regulation of the advertising of cosmetic surgery and other clinics.
- Stronger Ombudsman arrangements for dealing with complaints.

How these recommendations are put into practice is a matter for discussion but it would obviously be important to set up a process with the support of the industry. Self-regulation is unlikely to be strong enough.

APPENDIX 33

Letter From Dr G Martin to the Chairman of the Committee (PM 72)

I understand, from a newspaper article, that you are Chairman of a committee looking into safeguards in private medicine starting in the new year.

This is an area of medicine that I have a particular interest in having been involved in cosmetic laser surgery for the last seven years. I carry this work out in variety of clinics up and down the country and I regularly lecture on the subject here and abroad.

There is no formal recognised training for laser medicine and surgery in this country and I became interested in the subject from a background as a GP.

I therefore read articles in the paper and watch television programmes on the subject with great interest. I am certainly aware that comments about unqualified surgeons in newspaper articles is fairly meaningless, at least in the context of the area in which I work. I for instance have been involved in the training of NHS plastic surgeons, and am only too well aware of the fact that holding a position as a hospital consultant does not necessarily confer competence to use a laser. I believe that this parallel extends beyond my particular field.

There is one area which I find particularly misleading when it is represented by certain members of the medical profession.

The president of the Association of British Consultant Plastic Surgeons, who undertake cosmetic work, has recently been in the press on several occasions and appeared on the television. He makes several assertions which I think are wholly wrong and are never the subject of a right to reply.

1. He likens surgeons undertaking cosmetic work, who are not NHS plastic surgeons to pilots with private pilot licences, whereas his members are qualified to fly jumbo jets. As you will know the number of NHS consultant plastic surgeons is rather limited, and indeed not all of these undertake private work. What private work they do undertake is supposed to be carried out in their own time, when they are not contracted to do NHS work. It is of course well known that sometimes the distinction between these two areas is rather blurred. If one followed the above argument to its logical conclusion even the existing demand for cosmetic work could not possibly be met by these surgeons working in their private time. There would therefore be a vast reservoir of perfectly justifiable and genuine demand which would remain unmet.

2. There is an alternative organisation of surgeons undertaking cosmetic work, many of whom trained in the NHS for a considerable period of time but left having become disillusioned with the pyramidal career structure and the difficulty in obtaining a consultant job. Many of these surgeons spend all of their day doing exclusively cosmetic work whilst members of the other organisation spend much of their working day undertaking reconstructive surgery and dealing with burns patients. It is therefore extremely questionable whether NHS plastic surgeons necessarily have more experience in cosmetic work than these other doctors. What is certainly the case is that many plastic surgeons upon first taking up a consultant NHS position have very little experience in cosmetic work, since they have spent nearly all of their registrar training posts undertaking reconstructive surgery and working with burns patients.

I hope these two points illustrate graphically to you the difficulty of accepting the arguments of people at face value. I have no particular axe to grind in this matter, since I only undertake laser work, and not pure cosmetic surgery, but I feel that it is a point that should be made and well understood when your Committee eventually sits.

I do hope that when you take evidence you take it from as broad a base as possible, since I am convinced that there are powerful forces at work that would seek to blur the truth.

16 December 1998

APPENDIX 34

Memorandum by Capsticks (PM 75)

1. Capsticks has many years' experience as legal advisers to the Health Service and our work includes assistance across the full range of Health Authority powers and duties under the Registered Homes Act 1984 (the 1984 Act); we also have experience of advising on Local Authority responsibilities under Part I of the 1984 Act.

2. In submitting this Memorandum, we have taken into account the contents of Chapter 4 of the White Paper of November 1998, "Modernising Social Services", with its reference to the intended creation of Regional Commissions for Care Standards (CCSs) and also the contents of Health Service Circular 1998/233, "Modernising Mental Health Services: safe, sound and supportive", referring to the work of the National Service Frameworks External Reference Group. We have concentrated specifically on the role of the law in respect of the Select Committee's terms of reference.

3. The law is currently embodied, in particular, in the 1984 Act with its Regulations and in case law, mainly the decisions of the Registered Homes Tribunals. It has three distinct functions:

- (a) Definitions;
- (b) Setting standards;
- (c) Enforcement;

These are at present unsatisfactory for the following reasons:

- (a) Definitions: the 1984 Act is too broad in its definitions of the premises, services and facilities covered by the Act's regulatory provisions. For example, it has the effect of requiring Inspectors to spend time and money on overcoming owners' reluctance to believe that clinics intending to use class 3B lasers for hair removal require registration;
- (b) Setting standards: these are notoriously vague, turning essentially on "adequacy", with wide variation and subjective interpretations by different Health Authorities;
- (c) Enforcement: the enforcement processes although giving some scope for dialogue are elaborate, adversarial, and limited to prosecution and cancellation of registration. This has the result, for example, that if persuasion fails the removal of a member of staff deemed "unfit" can only be effected by means of a proposal to cancel the entire registration.

4. ACUTE GENERAL HOSPITALS

- (a) The 1984 Act while including these within its definition and thus requiring Health Authorities to register, monitor and inspect them, does not either in its formulation or in practice usefully apply to them. Not only is the scope for setting standards limited by the vagueness of the statutory definitions, but the professional backgrounds of the great majority of inspectors, in our experience, are as general nurses and mental nurses, in the care of the elderly, which is a symptom as well as a cause of the implementation and interpretation of the Act being almost exclusively concerned with premises providing care for older persons. There are however examples of good practice where particular Inspectors have been designated as specialists to inspect acute hospitals (and hospices)—which should be encouraged, by means of a network of specialist nursing and medical staff contributing their expertise within the CCSs;
- (b) This sector is already in part providing a good model, in terms of professionally agreed accreditation, not least by means of the King's Fund Scheme for acute hospitals, whereby self-regulation effectively takes the place of the statutory framework. This evidently has the result that the drawback mentioned above rarely results in problems with the standards of the premises and their facilities, because of the accreditation scheme, along with the incentive afforded to maintain high clinical standards by the staff's accountability to their professional organisations, for example the GMC and the UKCC. The current development of the National Institute for Clinical Excellence and the Commission for Health Improvement is clearly an appropriate model for the CCSs to adopt.

5. MENTAL HEALTH SERVICES

Bearing in mind the current work of the External Reference Group and the intended eventual amendment of the Mental Health Act 1983 (the 1983 Act), the following specific issues are relevant:

(a) EMI Homes

In practice across the country many Health Authorities have routinely maintained a category, within Section 21 of the 1984 Act, catering for "elderly mentally infirm" patients. This category, however, does not arise from an accurate interpretation of the 1984 Act and creates difficulties on occasion in achieving a placement which takes full account of a patient's current diagnosis and real healthcare needs. While mental health problems among older people cover a wide spectrum, and fluctuate over time, from temporary confusional states to dementia, the maintenance of this category is a legally unsatisfactory compromise, whose only real benefit may be the avoidance of the widely-perceived stigma attaching to "mental illness". Even within this, we have found that some inspectors have regarded "EMI" as in fact encompassing actual mental illness, and yet maintained the registration and staffing standards of general nursing homes under Section 21 rather than mental nursing homes under Section 22.

(b) Mental Disorder

Mental disorder, reflecting the breadth of the definition in the 1983 Act, is a registration category both for Part I homes and Part II homes, dealing respectively with "persons in need of *personal care* by reason of past and present mental disorder" and with "persons suffering, or appearing to be suffering, from mental disorder". The White Paper's approval of the concept of a single care home should result in the creation of such a single care home suitable for any person actually, rather than "apparently" suffering from mental disorder: this must await the conclusion of the External Reference Group's current work on the National Service Frameworks and the eventual amendment of the 1983 Act.

(c) Mental Health Act Commission;

At present, the Commission has broadly-defined powers to visit and inspect any premises in which detained patients are housed, and to investigate any complaints brought by or on behalf of such patients. In practice, the Commission currently has no real enforcement or standard-setting powers, contenting itself by reason of shortages of resources and staff with concentrating on premises' paperwork and having no real sanctions beyond criticism. Again, this must form part of primary legislative changes, to the 1983 Act, for the benefit also of private healthcare. If such legislative changes include the empowering of the Commission to inspect and monitor also premises housing informal patients, this would be likely to address the problem satisfactorily; alternatively the Commission should work in liaison with the CCS, to ensure that appropriate inspections begin to take place.

6. RECOMMENDATIONS: ENFORCEMENT

Establishment of the CCS, will greatly extend the scope and complexity of the regulation and inspection process. The current system of sanctions is unwieldy and draconian, and recourse to prosecution, with its higher burden of proof, is usually undesirable, in part because of the subjective interpretations of "adequacy". The creation of nationally-agreed standards should address this problem. But we consider that the legislative framework should still include enforcement sanctions, as a last resort, for non-compliance, in view of the vulnerability of the recipients of private healthcare and the financial incentives to "cut corners". We would suggest that a system of enforcement notices, to cover both breaches of condition and breaches of the regulations, should be instituted, in such a way as to allow for flexibility and proportionality; if there are recurrent breaches of such enforcement notices on comparatively minor aspects of the care or facilities, the inspectors could exercise their judgment as to the need for cancellation, while this evidence might be amassed as building up evidence of unfitness; whereas for a fundamental breach such as the failure to provide means of escape from fire the deterrent and punitive effect of criminal proceedings should still be available, with prosecution following such breach of the enforcement notice; and thereafter registration might be cancelled. Given the private sector's intended contribution both to the national agreed standards and to the composition and working of the CCSs, these might, with consequential savings in terms of costs and maintenance of co-operative relationships between the regulators and providers, assume less importance, with less need to threaten or resort to them: to everyone's advantage.

February 1999

APPENDIX 35

Letter from Carole Monteiro-D'Aguiar to the Chairman of the Committee (PM 76)

As a member of Silicone Support UK, I wish to raise the following issues with the House of Commons Health Care Select Committee on the adequacy and extent of regulation monitoring and inspection of healthcare outside the NHS. I am disappointed at the lack of balance on the Health Care Select Committee itself. At the present no representative from patient groups who are familiar with the types of problems that private patients frequently encounter has been invited to join the committee.

I have compiled this memorandum from my own experience and knowledge of having lived abroad and used a number of other health care systems throughout the world. I have lived in the USA, France, Portugal and Australia, in addition to the French Pacific Islands. During my time in New Caledonia I worked for the Economist Intelligence Unit supplying information on the local economy for publication in the EIU quarterly economic reports. However, due to ill health I had to give up the work and I made several trips to Europe to try to resolve my health problems and I became aware of the wide range of standards, fees and information that private patients are given when being treated in the UK.

Since my return to live in the UK in 1998 I have been involved in work with Silicone Support UK to raise awareness of the potential risks and problems that patients encounter when they experience adverse effects to surgical products. Silicone Support frequently helps patients who have had breast augmentation or reconstruction. A large percentage of these operations are for cosmetic purposes and this type of elective treatment is usually provided by the private health care sector. As a working member of Silicone Support I have regular contact with other members of the group and this has offered a further insight into the types of problems frequently encountered in the Private Health Care Sector.

Areas of concern which I feel need to be addressed are as follows:

1. Private Patients have no access to a regulatory body to voice complaints and to address any failure in the standards of care and treatment provided by the hospital or the doctors. All areas of care need to be regulated, patients have a right as paying customers to full disclosure regarding fees and likely future treatment costs, treatment options, informed consent and access to information to enable the patient to have their case managed efficiently and effectively throughout their lifetime. The lack of a formal system of complaints means that patients are often left without advice on follow up or long term care and their only form of redress is in the civil courts. Civil action is a lengthy and difficult

process and does not offer any solution for patients ongoing treatment needs. Patients need both a regulatory body to investigate serious complaints and a helpline to find treatment when their doctor or hospital has failed to respond to their complaints of pain and suffering. Patients should be advised in writing at the time of consent of treatment, how to access this complaints procedure and what to do in the event that they are seriously ill or in pain and cannot get help from their service provider. At the present time the NHS is required to deal with emergencies and complications which are the responsibility of the private sector even though it is very often the same doctors that work in the NHS who provide this privately funded treatment;

2. Treating Doctors do not always supply Private Patients with sufficient information regarding the surgical procedures/tests to be carried out prior to consent. Informed consent particularly when embarking upon non-emergency treatment must be more clearly defined for patients to assess the risks and the expense that they are entering into a contract for;
3. Surgical Products do not last a lifetime and private patients need to be made aware of the following:
 - Risks associated with product rejection and failure;
 - Written instructions on the care and maintenance and the eventual need for implant/prosthesis removal/replacement;
 - Estimated future cost of removal and replacement of the implant/prosthesis. Also to be included the frequency of check ups and tests/scans that will be required to determine that the implant is still functioning. (Patients are frequently unaware that removal and replacement is considerably more expensive than the original surgery or that eventual removal and replacement is even necessary);
4. Private Patients to be given written advice after any surgical procedure of any foreign materials that have been either temporarily or permanently placed inside their body. This information is to include details of:
 - All fixations, implants/prosthesis and suture materials. (Even suture materials, can cause long term post operative complications). Once a treatment which involves the placement of foreign objects has been commenced, these types of treatment often involve multiple surgeries throughout the patients life and patients have a right to the information for their long-term patient care and management. Biocompatibility is an important issue in any treatment and its successful outcome. The Product Name Type, Manufacturer and the Product Serial Number if appropriate;

The information will facilitate the following:

- Patients will be able to self-report product problems to the MDA. Product problems will be identified more easily and appropriate action can be taken in a shorter time than at the present. The 3m hip replacement recall took several years to be instigated after the doctors became aware that the product was not fit for the purpose. Several months after the product recall, their doctors or hospitals had located only 3,000 of the 5,000 recipients. This situation would have been avoided in many of these cases if product information had been provided at the time of implantation. The time taken by the healthcare industry to respond to such product failure is unacceptable and at the present relies too heavily on individual doctors/service providers to take action. Patients will have information regarding products already present in their body to pass to treating doctors. This is particularly relevant when a patient transfers from the Private Healthcare system to NHS. Private patients frequently uncover that product information was not recorded at the time of the original treatment and or medical records have been lost/destroyed;
5. Private patients to be sent copies of all Laboratory reports, analysing body tissues and fluids. The patient pays for these tests and services and a copy of the information should be given to the patient at the time the service is provided and paid for. Patients should also be advised that if they think that they may require a second opinion or further analysis to be carried out on the specimens that a portion of the samples are to be retained for this purpose. Tissue samples and body fluids are the property of the patient and any use of the specimens other than for the treatment of the patient is to be agreed with the patient in writing;
 6. Goods and services paid for as part of the treatment must be properly reported and made easily accessible to the patient. Scans, X-rays and other types of imaging are to be independently reported by a suitably qualified doctor, other than the treating doctor and a signed copy of the report supplied to the patient and a complete set of the images to be given to the patient. Where multiple images are taken a complete series of images is to be handed to the patient and not an edited or truncated edition of the scan. This will enable the private patient to seek a second opinion either in the UK or overseas should they wish to do so, without the need to repeat expensive and possibly invasive tests;
 7. Doctors and service providers are to be regularly inspected and the type of treatment offered to be assessed on a regular basis. This assessment should include:
 - The success rate of the treatment carried out in relation to other treatments available that offer similar results, which may be less invasive, cheaper and carry less risk. Performance of the treating doctor carrying out the treatment to determine if he/she works at a level which is comparable with other doctors in their field of expertise. Assessment of the type and quality of materials chosen for the treatment and the failure complication rate of the products;

Training standard and competence of support staff provided by the treatment facility to be monitored. That the quality of equipment and facilities where the treatment is to be carried out are of a standard that ensures that the treatment can be carried out safely. Staffing levels are adequate to provide the necessary after care for the treatment provided. Death rates/post-operative complication rates to be made available to the patient if they request this information before their treatment. Number of cases where post operative/treatment has required transfer of the patient to another facility and the reasons for the treatment provider's failure to offer complete patient management and care. Long term assessment of patient satisfaction with the treatment. Patients ability to lead a normal life, work, walk, drive etc should be taken into consideration and not just the doctors short term post-operative assessment. Patients whose life style and ability to resume a normal working life are adversely affected by their treatment ultimately cost the patient, their families and the state a considerable amount of money in the long term. In the event that a patient dies either during or shortly after an invasive treatment/test or surgery, a full post-mortem is to be carried out in order to determine the exact cause of death. Permission for this procedure could be included on the treatment consent form. Any research work undertaken for pharmaceutical companies which a patients doctor or the service provider are contracted to carry out which include the patient in the research must be agreed with the patient in writing. Any patient who is included in a test or trial is to be given written advice as to the risks that they are undertaking and advice as to who they can complain to if they experience any long term adverse effects that the service provider/doctor is no longer able or fails to respond to;

8. The cost of serious post-operative complications when private treatment is undertaken is often borne by the taxpayer via the NHS. Both the immediate treatment costs and the long-term costs related to the treatment of these patients should be shouldered by the doctor/service provider if the treatment supplied was not of a reasonable standard, the patients insurer or the patient themselves. Private Patient facilities often lack the necessary equipment and personnel to deal with serious treatment complications, the State should not have to bear these costs;
9. A private patient's guide should be drawn up setting out the standards of care and treatment that a patient can reasonably expect. Private healthcare facilities should provide minimum standards of care and access to a doctor. If the treatment facility cannot provide ICU care or access to diagnostic facilities, patients should be advised as to what alternative arrangements have been made in the event that these facilities should be required as part of their treatment. If facilities can only be accessed in the NHS, patients and their insurers should be made aware that this part of their treatment will be billed;
10. Private Patients are often required to pay for treatment/diagnostic tests in advance and they have little redress if the goods and services that they have contracted to pay for are not supplied in full or are of an adequate standard. A Code of Standards should be set by the new Regulatory body for all treatment/diagnostic tests, patients should be able to access this code to ascertain if they are receiving a reasonable standard of treatment. Patients should be given written advice regarding the service that they are purchasing and an explanation of what the test/treatment will provide. This will help patients to make an informed consent and prevent patients having unnecessary and/or invasive diagnostic tests carried out;
11. When the treatment provided fails to meet the standard that Patients expect, patients have little form of redress other than to commence legal action against the doctors/service providers. Litigation often ends in dissatisfaction and resentment from both sides. Our Group see a need to improve communications, customer services and rights, in order for the expense and the lengthy process of litigation to be avoided.

The British Healthcare system allows doctors to adopt a rather patronising role towards its paying customers and customers are not easily able to change service providers if they wish to do so. Doctors have a proprietary attitude towards patients, which make it difficult for patients to change service providers. Furthermore the lack of accurate information regarding treatment which has already been carried out mean that patients can feel they have no alternative but to return to the original doctor even when they are dissatisfied with the patient care and management that they have previously been offered. Patients require a referral via their General Practitioner and it is the GP who selects the specialist and not the patient themselves. A database which patients can access to research treatments that doctors and healthcare facilities offer would be useful.

The majority of the private healthcare system presently provides care and services for patients who are seeking elective treatment or non-emergency procedures, the rights of the individual both as a patient and a customer need to be protected in this growing area of the Healthcare Industry. I look to the Healthcare Select Committee to resolve the issues that I have briefly outlined above and if you have any questions about my comments or suggestions, please do not hesitate to contact me.

APPENDIX 36

Memorandum by United Kingdom Central Council for Nursing, Midwifery and Health Visiting (PM 78)**1. INTRODUCTION**

1.1 The United Kingdom Central Council for Nursing, Midwifery and Health Visiting is the statutory regulatory body for the three professions. Its purpose is to establish and improve standards of nursing, midwifery and health visiting care in order to serve and protect the public. The UKCC's key tasks, as set out in the Nurses, Midwives and Health Visitors Act (1997) are to:

- maintain a register of qualified nurses, midwives and health visitors;
- set standards for nursing, midwifery and health visiting education, practise and conduct;
- provide advice on professional standards;
- consider allegations of misconduct or unfitness to practice due to ill health.

1.2 The UKCC's evidence will focus on the input of its registrants to regulation and on its corporate business in dealing with complaints in addressing the terms of reference.

“To examine the adequacy and extent of the regulation, monitoring and inspection of private health care outside the NHS. The Committee will also take evidence on complaints procedures relating to such provision”.

2. ISSUES WHICH IMPACT ON THE BUSINESS OF THE UKCC

2.1 The UKCC is concerned that the Registered Homes Act 1984 does not meet the requirements of patients to protect them adequately in the current system. Modernising Social Services goes some way to addressing some of the issues in the plan to introduce Commissions for Care Standards. However, the current Act is out of date in that it cannot enable essential regulation and monitoring of health promotion, prevention of ill health or rehabilitation. The Act is a blunt instrument in that the only sanctions available are prosecution and deregulation.

2.2 Registration and Inspection Units are usually managed and staffed by registered nurses, midwives or health visitors. These registrants are accountable for the responsibilities they undertaken under the Act and through their registration. The practice of registered nurses in this regulatory activity often results in their having to give professional support and help to the persons in charge to maintain safe and acceptable working practices.

2.3 The UKCC currently has around 25 per cent of its 630,000 registrants employed within the private and independent sector. These registrants work in a variety of settings, only some of which are covered by the Registered Homes Act 1984.

2.4 The range of skills required by inspectors also has to cover the range of special categories including: forensic psychiatry, acute psychiatry, elderly mentally infirm, continuing care of the elderly, physically and mentally disabled children and adults, palliative care, dental clinics and medical and surgical hospitals. This range of specialities in the private and independent sector requires regulation that can respond to the very particular needs of these quite disparate services.

2.5 There are 200,000 beds available for inspection in all of these different settings, change in the legislation would allow inspectors to respond to the differences between them to take account of dependency, staffing requirements and facilities.

2.6 Independent midwives work within a professional regulatory system which protects the public through a system of supervisors and self regulation.

2.7 There are also many registrants who work in alternative therapy areas, beauty therapies and other unregulated areas, where the only protection for the public is the professional accountability of the registrants as nurses or midwives.

3. ISSUES FOR UKCC REGISTRANTS

3.1 There is increasing evidence that UKCC registrants are being employed in the residential care setting to meet rising dependency needs for older people who are not assessed as having a need for nursing care. Registered nurses are increasingly identifying this as an area where they are using their nursing skills. Although this area is currently regulated by local authorities, the UKCC is concerned that, whilst it is not a requirement to be a registered nurse in this setting, there is a felt need for the added value of a nursing qualification and subsequent protection of the public.

3.2 Registrants in the private and independent sector work alongside a range of other professionals, few of whom are regulated by other professional bodies. Health care assistants provide a range of tasks delegated and supervised by UKCC registrants.

3.3 The increasing number of health care assistants means that registrants are increasingly managing nursing services rather than delivering care directly, and accepting accountability for the health care assistants

who are being charged with increasingly higher level tasks. In its submission to the review of the Nurses, Midwives and Health Visitors Act 1997 (enclosed), the UKCC supported the view that health care assistants should be regulated.

3.4 *Modernising Social Services* goes some way to addressing the point in advocating the regulation of social workers and social care assistants, but excludes health care assistants. The UKCC feels that the division between health and social care is arbitrary and that all those working with vulnerable members of the public should be regulated.

4. COMPLAINTS

4.1 The statutory powers of the UKCC allows the profession to regulate itself. In dealing with conduct issues, the UKCC has the power to remove registered nurses, midwives and health visitors from the register. The UKCC is concerned that a number of these ex-registrants, or those under investigation, are able to secure employment in the private and independent sector. Regulation under the Registered Homes Act 1984 does not currently protect the public from those who have been found guilty of misconduct by a regulatory body.

4.2 Some 23 per cent of the complaints received by the UKCC are against registrants working in the nursing home sector. This represents 127 reports out of 533 which compared to the 630,000 registrants is a small number. However, this sector produces the second highest number of referrals to the preliminary proceedings committee for consideration of possible removal from the register.

5. CONCLUSIONS FOR CONSIDERATION BY THE HEALTH COMMITTEE

5.1 Any new legislation developed to replace the Registered Homes Act should take account of the diversity of services and needs required in the private and independent sector.

5.2 The Commissions for Care Standards must be able to take account of the external regulator's views on practice within the private and independent sector.

5.3 Regulation needs to be flexible and facilitative as well as authoritative.

5.4 Complaints to external regulatory bodies should feed in to the regulatory framework to allow for better protection of the public.

February 1999

APPENDIX 37

Memorandum by Health Quality Service (PM 82)

SUMMARY

We believe that there is a strong argument for regulating independent hospitals. We do not believe that there is sufficient evidence to demonstrate that the yet to be established CHimp or Commissions for Care Standards are the appropriate bodies to perform this responsibility. In our view the focus of regulation should be on improving quality and this is best delivered through nationally recognised quality systems that have been developed specifically for health care. In our view all hospitals should be encouraged to participate in one of these schemes to assure themselves, their patients and staff, that they are quality organisations and delivering quality services. It seems a pointless exercise and a potential waste of resources, to establish an alternative regulatory body when they already exist and meet the requirements of the national body responsible for providing accreditation of certification bodies.

THE HEALTH QUALITY SERVICE

The Health Quality Service is part of the King's Fund, an independent charity that aims to improve health and health care in the UK. In 1989 the Fund established a programme to look at the application of standards to hospitals. The Health Quality Service (formerly King's Fund Organisational Audit) is now the foremost standard-based assessment, review and improvement programme, specifically developed for the NHS and independent healthcare organisations. We work with acute and independent hospitals, care homes, community and priority care services, primary health care and primary care groups. Since 1995 we have been offering an accreditation programme to trusts and independent hospitals. More recently, the Health Quality Service was granted certification body status by the United Kingdom Accreditation Service, which allows us to offer certification to ISO 9002, as well as HQS accreditation. In our opinion regulation is about raising standards of quality.

Over 40 per cent of acute hospitals and an increasing number of non acute providers in the independent sector participate in our accreditation programme. We believe that our approach is unique and the response from the independent sector is a demonstration of the importance they attach to achieving and maintaining a quality service through the application of standards by an external and independent organisation.

This submission reflects our knowledge and experience of using accreditation and a standards-based approach to raising the quality of services in the independent sector.

WHY SHOULD THE INDEPENDENT SECTOR BE REGULATED

We believe that the independent hospital sector should be regulated for the following reasons:

1. All patients are entitled to be treated under the NHS and their right to high quality service should not be diminished because they choose to be treated in an independent hospital, instead.
2. About 10,000 NHS patients are regularly treated in independent hospitals, particularly those providing specialist care and treatment for the mentally ill and those with learning disabilities. The commissioning organisations who arrange these admissions and the patients involved should expect the standard of care and treatment to be no less than that provided in the NHS.
3. The arguments set out in the "Modernising Social Services" document against health authorities regulating nursing homes also apply to independent hospitals.
4. The regulation of care homes is based on the premise that there is a need to protect elderly, vulnerable people. The majority of patients treated in hospitals, including independent hospitals are also elderly and feel vulnerable. They also need to be assured that the treatment and care they receive is of a high standard and will be administered in a safe environment.

REGULATING THE CLINICIANS

We are extremely pleased that government has taken the bold step of placing quality at the heart of the NHS. The measures outlined in the White Paper "The New NHS" and the consultation document "A First Class Service: Quality in the New NHS" are very welcome. We are particularly pleased that attention is to be focused on clinical performance and professional self-regulation. The application of these measures will address the major anomaly that currently exists in both the NHS and independent hospitals. It will also ensure that the quality of clinical care and treatment is provided by individuals who are professionally trained, competent and keep their practice up to date. In this respect there is no need for any special attention to be paid to independent hospital consultants because professional self regulation and the delivery of care and treatment through clinical governance in the NHS, will cover the majority of consultants who work in both sectors.

Independent hospital managers will need to take steps to satisfy themselves that admitting rights are only granted to consultants who satisfy the national standards of clinical performance and professional self regulation.

REGULATING THE ORGANISATION

High quality care and treatment is not just dependent upon individual performance. It also needs an effective organisation with appropriately trained and skilled staff; supported by clear policies and procedures, with good facilities and equipment in a healthy and safe environment.

The independent hospital sector has already placed a great deal of importance on using formal systems of quality improvement and quality assurance in this respect. The Independent Healthcare Association has taken the step of requiring all its members to be accredited by a nationally recognised quality improvement and quality assurance scheme, which has been welcomed by the sector. Apart from other obvious business reasons for improving efficiency, the main reasons for this are:

- a desire to demonstrate that care and treatment in independent hospitals is as good as the NHS;
- they recognise the need to manage risks and avoid errors/incidents which could damage their reputation and result in significant claims;
- they are keen to demonstrate to insurers, commissioners and their policy holders that they can provide a quality service.

A significant number of independent hospitals now participate in credible quality certification/accreditation systems as a public demonstration of the high quality of care that the sector provides and to differentiate mainstream independent hospitals providers from fringe health care providers who have given the sector a bad name.

REGULATION BY WHOM?

We believe that the most appropriate way of regulating the independent hospital sector to achieve high standards of organisation and service delivery is through participating in a nationally recognised external quality improvement and quality assurance system. The United Kingdom Accreditation Service has been set up by the Department of Trade and Industry to regulate quality assurance and quality improvement systems. For this reason it would seem entirely inappropriate to establish an alternative regulatory system for

independent hospitals when they already exist. The most successful of these in the health service has been Clinical Pathology Accreditation, set up by the Royal College of Pathologists to address poor quality in laboratories. Eighty per cent of all NHS and independent hospital laboratories are now accredited. We would endorse the minister's statement that organisations must choose locally, which of the range of quality improvement tools, including accreditation systems, they use to help improve services. We also believe that this should apply to the independent sector as well. In making their choice we would suggest that the following criteria is used:

- The system should not just focus on inspection but should include a developmental focus;
- It should involve national standards which are wholly applicable to the sector;
- The sector should be involved in the development of those standards, the focus of which should be to achieve best practice;
- The process of assessing compliance should be conducted by assessors who are knowledgeable and experienced in the sector;
- The system should be based on continuous quality improvement.

The Health Quality Service is well placed to meet all of these criteria and the standards we use already address the same range of issues outlined in government policy as follows:

- Clinical audit;
- Medical and nursing records;
- Health and safety;
- Induction and training of clinical staff;
- Clinical risk management;
- Clinical governance;
- Corporate governance;
- Controls assurance.

The standards are addressed with the same rigour as in the NHS. Indeed, many NHS trusts participate in our programmes and maintain that they are extremely beneficial in raising standards. The United Kingdom Accreditation Service has endorsed our approach and awarded certification body status which enables us to provide quality systems certification to the ISO 9000 series of standards.

We do not think that it is appropriate for the Commissions for Care Standards to regulate independent hospitals. The range and complexity of services they provide make them wholly unsuitable for regulation by these new bodies. The level of knowledge and expertise required to conduct inspections would be much greater than exists at present within health authorities inspection units. It would also be necessary to develop a different set of standards for independent hospitals to reflect these important differences. It is our view that independent hospitals are much closer to NHS hospitals than nursing homes and as such, the same conditions that apply to NHS organisations concerning their employment of health care professionals will equally apply to those employed by independent hospitals. For these reasons it would not be appropriate for independent hospitals to be regulated by Commissions for Care Standards.

Hospital managers within the independent sector will have a responsibility for ensuring that the consultants who practice in their hospitals conform to national standards of performance, established by NICE and that they meet the requirements imposed by self regulation. To enforce this it might seem appropriate to extend the remit of CHimp to include the right of inspection of independent hospitals. Whilst CHimp's scope permits in-depth assessment of NHS organisations, the sheer volume of work and resources required would only allow this to happen in extreme cases. We believe that extending this to include independent hospitals would place a considerable burden on this new organisation. Although it is not yet entirely clear who will pay for inspections, it would be difficult to justify a different arrangement for independent hospitals from NHS hospitals.

CONCLUSION

In conclusion, we support the ministers comments that "NHS organisations must choose locally, which of the range of quality improvement tools, including accreditation, they use to help themselves to improve services". It is our view that independent hospitals, together with NHS hospitals should be actively encouraged to participate in a nationally recognised quality improvement and quality assurance system.

APPENDIX 38

Memorandum by the Heart Hospital (Gleneagles Hospital (UK) Limited) (PM 87)

THE REGULATION OF PRIVATE AND OTHER INDEPENDENT HEALTHCARE

1. EXECUTIVE SUMMARY

1.1. The Heart Hospital is a state of the art specialist hospital providing the highest standard of cardiac healthcare in the UK and world wide. It is one of the world's leading centres for the treatment of cardiovascular disease both adult and paediatric.

1.2 The Heart Hospital supports regulation for all private and independent healthcare based on promoting fairness and competition. On both adequacy and extent the current system of regulation falls short. If not addressed, this will increasingly be the case within the context of an evolving healthcare system where private provision will increase.

1.3. Recommendation: Overall there should be national standards for regulation, monitoring and inspection of private and other independent healthcare covering any incidence where a patient pays for treatment at the point of delivery either directly or through a private healthcare insurer. This national standard would encompass private hospitals, independent hospitals, private facilities in NHS hospitals and medical clinics.

1.4 Effective regulation is necessary to prevent mistakes being repeated in the UK which have occurred elsewhere, such as in the United States where it can be seen that poor regulation has left the system open to abuse.

1.5 The Heart Hospital recognises that the need for effective regulation will be a common theme in submitted evidence so we wish to concentrate on two elements and encourage the Committee to make recommendations to the Government to address:

- (i) The need to enforce regulation as it relates to vertical integration and transparency when a private health insurer is also a private healthcare provider. In the UK both PPP and BUPA provide examples of this.
- (ii) The importance of a commitment to the highest standards to run in tandem with regulation so that regulatory requirements are not seen as the "norm" but instead as the bare minimum.

1.6 The Heart Hospital supports the principle of networks and vertical integration but has real concern that there is insufficient regulation in these circumstances.

1.7 The hospital has expressed this concern in a submission to the OFT's current inquiry and issued a formal complaint against Private Patients Plan (PPP) asking the Director General of Fair Trading to investigate the matter.

1.8 Recommendation: In cases of vertical integration there must be full transparency of the businesses and comprehensive published criteria upon which hospitals are selected for preferred provider networks which can withstand independent scrutiny.

1.9 The Heart Hospital and its parent group, Parkway Group Healthcare, is committed to staff training and education to maintain standards of excellence. The Heart Hospital is committed to achieving quality and performance initiatives.

1.10 Recommendation: Hospitals in the private and independent sectors should have a timetable for achieving quality and performance initiatives including ISO 9002, Investors in People, and Kings Fund Accreditation and regularly monitor progress towards achieving them.

1.11 Recommendation: Hospitals in the private and independent sectors should strive towards the highest standards in clinical governance and adopt an approach to "Modern Patient Care" where all relevant information on a patient is up to date and readily available.

1.12 The Heart Hospital would be happy to provide the Committee with appropriate additional information on request. Due to the necessary concise content of this submission The Heart Hospital would be happy to elaborate and expand on our comments by giving oral evidence to the Committee should that be required. Should the Committee want to visit The Heart Hospital this can also be arranged. Alternatively our website address is www.heart.org.uk.

2. INTRODUCTION

2.1 Gleneagles Hospital (UK) Ltd, owner of The Heart Hospital (The Heart Hospital), is a subsidiary of Parkway Group Healthcare. Parkway is the largest owner/operator of private hospitals in South East Asia. The Heart Hospital is their first European hospital. It is the result of a £45m investment which opened in October 1998.

2.2 The Heart Hospital is a state of the art specialist hospital providing the highest standard of cardiac healthcare in the UK and worldwide. It is one of the world's leading centres for the treatment of cardiovascular disease both adult and paediatric.

2.3 The Heart Hospital is built on the site of the National Heart Hospital established in 1850 as the first hospital in the world to be dedicated to the treatment of patients with cardio-vascular disease. The National Heart Hospital became internationally renowned and in 1966 performed the UK's first heart transplant.

2.4 The development of The Heart Hospital will build on this first-rate track record drawing on the skills of the leading consultants and dedicated staff associated with the hospital and the state of the art technology invested in it.

2.5 The hospital has 95 beds, four operating theatres, three cardiac x-ray laboratories and extensive day care and out patient facilities. The Heart Hospital creates a centre of medical excellence in the UK and also brings major overseas investment and will provide over 250 jobs.

2.6 Its principle officers are Rt Hon Sir Richard Needham, Chairman and Richard Dodds LLB (Hons) DipHSM, Chief Executive. Leading doctors associated and practising at the hospital include Professor Marc de Leval MD FRCS and Dr Anthony Rickards.

3. OUR EXPERIENCE

3.1 The UK's healthcare system is unique. The NHS is not only the most advanced system of state healthcare provision but a defining feature of the country's collective psyche. The Government's task is how best to ensure the state, private and independent sectors work most efficiently together in the interest of patients and taxpayers, to share information and best practice. As and when appropriate The Heart Hospital works with the local NHS health providers to and has proved that the private sector can offer real value for money to the NHS.

3.2 The context within which The Heart Hospital sees a role for regulation is the belief that the shape of healthcare provision in the UK will continue to change with private provision playing an increasing role.

3.3 The challenge in the non-NHS sector is effective regulation. At present only interventional surgery is regulated in the private sector. Out patient and non-interventional healthcare are not regulated, neither are private patient facilities in NHS hospitals whether run by a Trust or third party.

3.4 The Heart Hospital supports regulation for all private and independent healthcare. On both adequacy and extent the current system of regulation falls short. Regulation should be based on promoting fairness, a level playing field and competition.

3.5 Regulation should cover any incidence where a patient pays for treatment at the point of delivery either directly or through a private healthcare insurer. This national standard would encompass private hospitals, independent hospitals, private facilities in NHS hospitals and medical clinics.

3.6 In an evolving healthcare system where private provision will increase, regulation is required to prevent mistakes being repeated in the UK which have occurred elsewhere: Fraud in the US healthcare industry has been endemic for decades but in recent years has grown in scale and impact. The US Department of Health and Human Services reported that in fiscal 1997, it had identified \$1.2 billion for collection in fines, restitutions, settlements and recoveries.

3.7 The Heart Hospital recognises that the need for effective regulation will be a common theme and so we wish to concentrate our evidence on two key features:

- (i) The need to enforce regulation as it relates to vertical integration and transparency when a private health insurer is also a private healthcare provider. In the UK both PPP and BUPA operate in this way within their network of preferred providers;
- (ii) The importance of a commitment to the highest standards to run in tandem with regulation so that the regulatory requirements are not seen as the "norm" but instead as the bare minimum.

4. VERTICAL INTEGRATION AND TRANSPARENCY

4.1 There have been a number of MMC and OFT studies of the private healthcare sector in recent years. The 1994 MMC report on private medical services anticipated that private healthcare insurers would develop networks and recognised the role networks could play in controlling costs for insurers and premiums for customers.

4.2 To this extent The Heart Hospital supports the principle of networks but has real concerns that there is insufficient regulation of them. In particular regulation is failing to ensure transparency and effective "Chinese walls" where a private health insurer is also a private healthcare provider. When there is vertical integration of this nature, the network selection criteria must be far more comprehensively laid out than at present and open to independent audit.

4.3 The Heart Hospital and a number of other private and independent hospitals believe that one insurer in particular, PPP, which has a financial interest in its own hospitals, is acting anti-competitively in this respect

by unfairly treating hospitals in which it has no financial interest. The Heart Hospital has expressed this concern about insurers' criteria within the context of a vertically integrated network, in a submission to the OFT's current inquiry. We anticipate that the inquiry will lead to a referral to the MMC.

4.4 All other leading UK private health insurers have included the Heart Hospital in their networks. PPP has a substantial market share in the private health insurance market, both nationally (around 40 per cent) and in particular in the South East (an estimated 60 per cent—of episodes of care). The Heart Hospital is of little doubt that PPP's decision is motivated solely by its concern to protect its interest in certain London hospitals against new entrants into the healthcare market.

4.5 Many independent senior cardiologists and the London Consultants Association which represents over 300 of the capital's leading consultants have also contacted The Heart Hospital and the OFT making it clear that they wish to refer PPP-insured patients for specialist cardiac treatment at The Heart Hospital.

4.6 In addition to The Heart Hospital we understand that a number of London's other leading hospitals including Guys/St Thomas, UCLH, Queen Charlotte, Chelsea and Westminster, Queen Square, Middlesex and Western Eye have also been informed that they are to be removed from the PPP network from April 1999. UCLH have also made it clear that they consider this to be blatantly unfair and discriminatory especially as the PPP/Columbia hospitals are situated so close.

4.7 PPP's partner in its London hospitals is the American healthcare provider Columbia/HCA Healthcare Corporation. Columbia/HCA is the largest organisation of its type in the world. It is a vertically-integrated company which owns and operates over 300 hospitals and healthcare facilities worldwide. In March 1997 the FBI, IRS and HHS executed search warrants on some Columbia/HCA offices as part of an on-going investigation into allegations of potential healthcare fraud. Legal actions and investigations continue.

4.8 One affidavit quotes a confidential witness describing Columbia employees as predators, prowling the halls of Columbia/HCA hospitals "hunting" for patients to refer to Columbia/HCA owned home-health operations. Confidential witnesses also allege that Columbia/HCA awarded bonuses to some of its co-ordinators if they recruited more than 50 per cent of the Medicare patients discharged from Columbia/HCA hospitals to the company's home-health facilities.

4.9 Private healthcare providers may be seeking to develop similar networks in the UK. In an extract from "A Look to the Future"—Columbia.HCA company strategy statement 1998, the company outlines its intention to "build strategic provider networks in our communities". The strategy document also states that the company will seek to add new facilities in markets outside the London area.

5. STANDARDS AND CLINICAL GOVERNANCE

5.1 Whilst The Heart Hospital sees a role for regulation there are a number of measures which hospitals can introduce to ensure the highest standards of care, auditing and monitoring are in place.

5.2 The Heart Hospital has developed best practice based on training and education & regular auditing and monitoring which creates the healthcare environment necessary to provide the highest level of care in the private sector.

Training and Education

5.3 The Heart Hospital and Parkway Group Healthcare is committed to staff training and education to maintain standards of excellence. The Heart Hospital has a dedicated education department linked to a range of London academic institutions and universities to maintain and develop appropriately skilled staff.

5.4 The Heart Hospital also holds regular seminars, including the use of instantaneous video imaging for doctors and patients to communicate over different sites and different countries. These services are open to NHS and other external staff in the interest of sharing best practice with each other.

5.5 The Heart Hospital is committed to achieving quality and performance initiatives including Investors in People, ISO 9002, and Kings Fund Accreditation. ISO 9002 and Kings Fund Accreditation will establish recognised processes to provide developed and documented methods for preventing problems and meeting customer standard expectations.

5.6 Potential problems are identified and recorded to prevent future occurrences and corrective actions are developed. It will also ensure that The Heart Hospital is a healthy and safe place for all customers and staff. As well as improving operational efficiency the process improves communication and teamwork as matters are discussed and problems resolved. With this The Heart Hospital can build on other quality initiatives such as Total Quality Management Certificate and IIP.

Clinical Governance—Auditing and Monitoring

5.7 Audit tools are in place which ensure a high standard of clinical practice is maintained at all times. "Modern Patient Care", The Heart Hospital's revolutionary IT patient administration system provides for immediate access to all a patients' records, essential to effective monitoring. The system details patient

information, their referring physicians, diagnostic codes and all relevant administrative details. The documents are processed using standard software packages and immediately recall details and procedure reports which become part of the medical record.

6. RECOMMENDATIONS

6.1 Overall there should be national standards for regulation, monitoring and inspection of private and other independent healthcare covering any incidence where a patient pays for treatment at the point of delivery either directly or through a private healthcare insurer.

6.2 A national standard for complaints in private and other independent healthcare covering any incidence where a patient pays for treatment at the point of delivery either directly or through a private healthcare insurer.

6.3 Health Authority inspectors should be able to inspect all healthcare facilities not solely those where interventional surgery is carried out.

6.4 Health Authority inspectors should have the responsibility of carrying out independent regular audits of all and have powers to inspect a facility as part of a legitimate.

6.5 In cases of vertical integration there must be full transparency of the businesses and comprehensive published criteria upon which hospitals are selected for preferred provider networks which can withstand independent scrutiny.

6.6 Hospitals in the private and independent sectors should have a timetable for achieving quality and performance initiatives including Investors in People, ISO 9002, and Kings Fund Accreditation and regularly monitor progress towards achieving them.

6.7 Hospitals in the private and independent sectors should strive towards the highest standards in clinical governance and adopt an approach to "Modern Patient Care" where all relevant information on a patient is up to date and to hand.

APPENDIX 39

Letter from Mr Arie Carmon to the Chairman of the Committee (PM 90)

May I express my wife and my sincere appreciation of the work of the Health Committee in investigating the aspects of accountability in private health care.

Last Thursday *The Times* published an article relating my wife's experience with a BUPA service. As I am not in the UK at the moment, I printed the article from their WebPages. I am enclosing a copy of the article for your information¹ as it appeared on the Web. You will find this article a factual report of events, however, what I find incredible is BUPA's response as quoted at the end of the article.

BUPA are quoted as taking very seriously any case involving a patient suing a consultant and that they would investigate the complaint thoroughly. They say that they looked at our complaint (against Dr Page) and had no reason to investigate it further. I would like to ask them how did they deal with this complaint? I can confirm that except for a formal defense that passed responsibility to the consultant as an independent contractor, we have had no evidence of any attempt by BUPA to investigate the complaint. Also my solicitor confirms that we have never received any input from BUPA that they are in the course of such an investigation or will undertake one once litigation results are known. So what sort of an investigation did BUPA conduct that cleared Dr Page almost instantly after our settlement? I am contrasting this claim with Dr Page's own admission of liability, which was made without even contesting it in court.

I suspect the answer lies in that Dr Page must have committed a beginner's error of a young practitioner. She accepted a task in breast imaging for which she was not yet sufficiently qualified to act as an independent consultant. I hope that by being found accountable she will avoid repeating these rush actions with future patients.

However BUPA were amiss in:

- (a) Having engaged Dr Page to do an independent diagnosis in breast imaging that is not her interest subject in radiology (Dr Page's own written testimony) and in which she lacked the experience (volume of diagnosis) prescribed in NHS trust mammography centres
- (b) By not following the National Standards for Breast Screening Service procedures and failing to engage a second radiologist as a cross check to Dr Page's diagnosis. If BUPA had followed this procedure, chances were that another radiologist, hopefully with interest in breast imaging, would have come up with the correct diagnosis that could have saved my wife.

What accountability does BUPA bear for exposing the public to the work of under-qualified consultants with inappropriate focus in radiology and ignoring the accepted procedures of cross checking to ensure the quality of the diagnosis?

¹ Not printed.

It is our hope that the Health Committee will find out the answers to these questions and help create regulations that will ensure accountability by the private health care services. We were users of private health care ourselves and do appreciate their potential contribution to public health services. However, BUPA and similar organisations being public services must, therefore, provide a viable service and be accountable on failing to provide an acceptable standard of service. By lack of enforcement through accountability they will naturally decline into a service with its prime focus on profit. Such a trend will invariably be at the expense of its users and as we are dealing in health care it will also risk lives.

6 March 1999

Dear Mr Hincliffe,

Re: Mrs Hadassa Carmon

I would like to take this opportunity to relate to you my wife's experience in using a medical service offered by BUPA. Although we had some other experiences with the system, I wish to relate only the one which formed part of our recent litigation into medical negligence.

Both my wife and myself were paying members of BUPA health insurance for a number of years. Together with the greatest part of the UK population we held that image of BUPA of providing the best in Private Healthcare with better and prompter service compared to the NHS Trust Hospitals. It all started when we decided that it would be appropriate for both of us to undergo a health screen. BUPA advertises this medical service stressing its importance for both men and women. The program for women was called Well Woman and included an examination of the breasts and a mammogram. As we live in Reigate, Surrey, our nearest BUPA medical center is BUPA Gatwick Park Hospital where we made an appointment for the screening.

My wife went for her examination on 16 April 1992. The diagnosis made by the radiologist on that date noted the presence of calcification but he reassured my wife that these are probably benign. However, the radiologist recommended that if my wife was concerned then she should return for another mammogram in six months to a year. I would like to add that this was the first time in her life that my wife had a mammogram and the whole procedure was new and unfamiliar to her.

On 22 January 1993, she went again just for the mammogram as she was not a person to ignore health issues. On that date another radiologist made the diagnosis and her observation was of no significant change and no further abnormality. Consequently, my wife was told by Dr Pinter, BUPA's Health Screening doctor, that she does not have to come again except for the routine checks (at the time it was recommended that these take place once every two years).

Notwithstanding the above recommendation, my wife went again for another mammogram check on 31 May 1994 and once more she was given the "good news" by yet another radiologist that there was no detectable malignant change.

We both have family in Israel and we used to go to Israel for holiday once or twice a year. Invariably, we went over Christmas and New Year. We did the same in December 1994. In the past I have made contact with a GP in Israel who impressed me very much with his thoroughness and medical knowledge. As I sometimes did in the past, I decided to have a private check up and my wife came along with me for the appointment. Dr Cohen, used the opportunity of seeing my wife to offer her a check too, it was completely opportune, as she was not too concerned with any major problem apart from some back pain that we all seem to have at some time in our life. However, during this examination Dr Cohen discovered a lump in her breast and immediately referred her to an imaging clinic for an ultrasound and a mammogram. On 25 December 1994, she had this examination and was told immediately that she has cancer and should do a further examination such as a biopsy.

From this point on my wife became an oncology patient at a local hospital and was basically grounded in Israel. After being let down by what was to her a select medical service in the UK she has lost confidence in the capability of this service and was not inclined to interrupt the help she received in Israel to return to the UK. Cancer is life threatening and one does not gamble with one's life. The UK medical service looked to us at the time as a dangerous gamble with my wife's life. I continued to shuttle between Israel and the UK in order to hold on to my work. However, in due course I had to give it up too and more or less retire to look after my wife with only occasional activity as consultant in my field of engineering.

We have taken up litigation for medical negligence. Of the three radiologists we only made a case against the second radiologist although all three seem to have been negligent. We did not sue the first one because of some doubt whether an "average skilled radiographer" would have been expected to identify the suspicious nature of the findings. All experienced radiologists we talked to had no doubt about it, but legally speaking, we needed to make the case for an average skilled practitioner. In the case of the third radiologist there is no doubt of his incorrect diagnosis. But again, legally speaking, we were advised by experts that my wife's illness had already spread by that time and had he made the correct diagnosis it would not have contributed much to her chances of survival. So there would not have been much of a chance to collect damages. The information we have been given by experts states that if the first radiologist had alerted her for suspicious signs, she would have had nearly 100 per cent chance of being cured. Even at the time the second mammogram was taken there was still 80 per cent chance. Today she is at stage IV cancer with chances that are not very bright.

We felt that there should have been some liability taken by BUPA hospital as they have selected all three radiologists for the task of interpreting my wife's mammograms. We were completely in BUPA's hands in determining who will undertake to diagnose these mammograms. It seems that none of these radiologists was actually skilled enough to come up with a correct diagnosis and make the right recommendation to the patient.

The Well Woman Service is a BUPA health service product for which we paid a fee. All we knew was that BUPA was behind this product and therefore we assumed that the highest quality of specialist would be engaged to conduct and interpret the results. As we learned later this has not happened.

The second radiologist, who admitted liability, took up her post as NHS radiology consultant only on 1 January 1992, that is three months before my wife's examination. Although this radiologist had some training in mammography, it was not her sphere of interest, which actually is in interventional radiology. At the time of my wife's examination this radiologist stood in for a colleague who was stated to have an interest in breast imaging. Also by her admission she is only looking at less than 1,000 mammograms per year. The required average for a radiologist with interest in mammography, we were told is 5,000. We felt that BUPA holds some liability in accepting this radiology practitioner to carry out mammography without having the necessary experience to do so. However, in response to our claim BUPA denied accountability on the grounds that the radiologist is an independent contractor and therefore solely responsible.

Our solicitors advised us that we might not have a case against BUPA based on the current legal situation but that the fault lies with the regulations of private hospitals, which allow them to offer medical services but avoid accountability. It is for this very reason that we are now presenting our story to you, Mr Chairman, with the hope that the Health Committee will come up with some recommendations to place accountability also in Private Hospitals such as BUPA Gatwick Park Hospital as it is with NHS Trust Hospitals.

I would like to make one last point. In the course of our litigation we have learned about the Standard for National Breast Screening Service originally proposed by Sir Patrick Forest in 1988–89. This Standard has been introduced in all NHS Trust centers of mammography and provides a measure of safety against misinterpretation of results by prescribing a methodology consistent with quality procedure. On learning some of the details of this procedure, we strongly believe that my wife would have had the correct diagnosis and recommendation from this screening service if BUPA had pursued these procedures. In their defence, BUPA have included a witness statement of the person in charge of the imaging services at Gatwick Park Hospital. Nothing in the procedures outlined by her as being applied at that hospital seem to relate to the recommended practices outlined by the National Standard of Breast Screening Service. Thus we can only conclude that the service provided by BUPA falls short of the standard applied by NHS Trust centres of mammography. We ask ourselves, is BUPA responsible for introducing and following these accepted standards of good medical practices and can they be held accountable for it or is it admissible for them to place all the blame on the consultants to whom they have granted admitting rights.

Arie Carmon

APPENDIX 40

Memorandum by Hospital Consultants and Specialists Association (PM 91)

"A scandal of the proportions of the Bristol baby hearts saga is waiting in the wings to happen in the private hospital sector."

This prophecy was made by Mr Winston Peters, President of the Hospital Consultants and Specialists Association (HCSA) to its Executive Committee meeting on 24 February which has put the need for clinical governance measures in private practice at the top of its agenda for the last four months.

Mr Peters also put the same point to representatives of BUPA in talks held on the same day (24 February).

The HCSA's conclusion is that two courses of action have to be taken simultaneously to improve quality control in private hospitals and prevent the rare "rogue doctor" working in a sector which has fewer safeguards than the NHS.

Firstly, the stringencies of the Government's plans for clinical governance in the NHS must be adopted by the private sector to allow poor performance in private hospitals to be picked up and dealt with.

Secondly, there must be closer correlation between the two sectors, so that disciplinary measures taken against a doctor in one sector is matched by similar action, or at least investigation by the other sector. For the two sectors are thoroughly intertwined and cannot be separated from each other.

Therefore, the HCSA also supports the BMA's contention, put to your Committee on 31 January 1999, that private doctors, hospitals and insurers should be subject to common sets of monitoring systems and complaints procedures.

The media has been awash with stories about doctors who have been suspended or dismissed from the NHS, either through their professional or personal behaviour, who continue to practise in private facilities.

The cases of Kent gynaecologist Mr Rodney Ledward, who was struck off the register by the GMC last September for gross incompetence, and Northallerton gynaecologist Mr Richard Neale, who was the subject of a BBC TV Panorama exposé on 1 March, are well documented.

But the situation must be put into context. It should be stressed that the very reason for these doctors' high media profile is their rarity which determines their high "news value". The number of "rogue doctors" uncovered in the last few years barely makes it into double figures—a tiny fraction of the 25,000 senior hospital doctors in the UK.

However, the HCSA is no apologist for the incompetence and bad behaviour of a tiny minority of rotten apples, and our Association prides itself on its founding principles to improve the quality of service offered by medical specialists.

It is through our Association's desire to improve the image of consultants that it is campaigning to improve the safeguards for patients in the private sector and close the loopholes which appear to exist.

Yet the only private group which appears to have grasped the nettle so far is BUPA Hospitals. BUPA rules state that, if a consultant is suspended by his NHS employer, BUPA will temporarily suspend that consultant's visiting rights to BUPA hospitals.

BUPA has also recently amended its rule book to stipulate that the chairman of each hospital's Medical Advisory Committee (MAC) is to be held responsible for monitoring the quality of doctors to whom his committee grants visiting rights.

The HCSA's view is that, while this is at least a positive step to deal with the problem, it places a huge burden on the MAC chairman, who does not have the power to institute proper audit or monitoring systems and who is sometimes not even medically qualified.

HCSA members have also pointed out that, while the medical director of an NHS hospital knows his consultant workforce well, the part-time chairman of a private hospital's MAC cannot possibly know the abilities of the scores of doctors performing the occasional procedure there.

This Association has held exploratory talks with BUPA representatives on the subject of quality control in private practice. It was agreed a joint working group of the two organisations should be established to discuss the topic in greater detail.

There are only rare cases reported of a consultant banned from working in a private hospital who has subsequently been suspended by his NHS hospital as a direct consequence. But talks held between HCSA officers and the chairman of the Nuffield in January, revealed the Nuffield's view that if a consultant was suspended by a private hospital, it should not necessarily affect his NHS employment.

While the HCSA supports the principle that suspension from working in the NHS should lead to suspension from working in the private sector, and vice versa, it has several caveats to stress.

The first is that automatic suspension from working in the private sector following suspension by the NHS should only be in cases of professional misconduct and cases of personal misconduct where the police are involved or where there is an immediate danger posed to the public.

The second caveat relates to the flaws in the existing system for dealing with suspension, the principal manifestation of which is the inordinate length of time consultants' careers remain on hold while their employers engage in "fishing expeditions" to find the evidence to incriminate the clinician.

The HCSA believes that eradicating the faults in the system of suspending doctors must go hand in hand with any plans to improve regulation of the private sector. For our Association is determined that doctors falsely accused must not have their private practice damaged by the NHS's poor handling of and rash recourse to the suspensions system.

This system's faults are lucidly described in a report published in January by the Working Group of the Society of Clinical Psychiatrists entitled "*A Blot on the NHS Landscape: 2*", written by Dr Harry Jacobs and Dr Peter Tomlin.

HCSA President Mr Winston Peters attended a conference of interested parties chaired by Baroness Knight of Collingtree at the House of Lords on 10 March, from which a consensus statement on how best to reform the suspensions system will be published.

The HCSA view is that there are too many instances where doctors have been wrongfully suspended from the NHS or have been left suspended for too long without their case being dealt with.

So any action initiated to improve quality control in the private medical sector must also tackle the shortcomings of the NHS suspensions procedure.

1. One recommendation Mr Peters took to the Lords' meeting is that an outside body should be brought in as soon as a doctor has been suspended for one week. This group should have the power to reinstate the doctor if it finds the accusations frivolous or motivated by personal rivalry. It could, of course, agree to continue the suspension and indicate when it will come back to revisit the problem after more evidence has been gathered.

The HCSA view is that this outside group to arbitrate and monitor should be modelled on the exemplary procedures devised by Poole Hospitals NHS Trust. These procedures stipulate that the outside panel be led by

a legally-qualified chairman from the Lord Chancellor's office and include a member of the Joint Consultants Committee, as well as representatives from management and a representative chosen by the suspended doctor.

2. Another recommendation Mr Peters called for is the introduction of a new right for a suspended doctor to take his case to a court if nothing has been resolved at the end of six months.

This would force the authorities to either sack or reinstate the doctor. If left suspended for longer, the doctor would find it well-nigh impossible to pick up his private practice, let alone keep up with medical practice.

3. Mr Peters also urged the Lords' conference to lobby for a compensation system for doctors reinstated after wrongful suspension. This would not only act as a deterrent against malicious or frivolous accusations against doctors, it would also reimburse them for lost private practice earnings.

For although doctors are suspended on full pay from the NHS, they would be prevented from working in private practice if the HCSA's policy of linking NHS suspension to private sector suspension is made law.

4. Another improvement to the suspensions' procedure Mr Peters demanded is a strict definition of who can suspend and on what evidence. Too often doctors have been suspended on weak, manipulated and contrived data.

The HCSA view is that the decision to suspend should be made by the medical director and must follow consultation with one of the panel of "Three Wise Men"—experienced consultants already established under current NHS disciplinary procedures.

Obviously, in the absence of the medical director or in cases involving the medical director himself, the chief executive must follow the procedure outlined in the previous paragraph.

With the advent of clinical governance, the chief executive must be made responsible for suspension at all times, since the rules of clinical governance lay the duty for overseeing quality issues at the door of the chief executive.

But the HCSA view is that suspensions must still be made by the medical director using powers invested in him by the chief executive.

5. It must also be stressed clearly from the outset what the charge is, whether professional or personal misconduct, and Trusts must not switch between charges simply to get one to stick.

It is the HCSA's view that most of the cases involving suspended doctors relate to doctors' behaviour, rather than competence. As one member of our Executive Committee, who is a medical director of an NHS trust put it: "These cases usually involve dysfunctional people in dysfunctional departments".

Many cases of suspension could be resolved if the doctor was retrained in some area of his or her expertise. But no-one has yet tackled the question of who holds responsibility for retraining the doctor, who pays for it and who signs off the doctor as being successfully retrained.

Even in the Bristol baby heart death scandal—whose public inquiry findings the HCSA does not wish to pre-empt—the issue was not just of competence. There were also faults in the system which allowed them to introduce a new procedure in paediatric cardiothoracic surgery without receiving outside expert tuition.

But the public inquiry into this sad episode could well lead to improvements in the way consultants' fears of their colleagues' clinical shortcomings are reported, logged and investigated.

A properly-constituted system of this kind, where faults could be reported and examined under controlled circumstances, without prejudice, to eradicate petty jealousies, will be a big step to eradicating future tragedies in both the public and private sectors.

The General Medical Council last month voted to adopt the principle of having a doctor's registration linked to successful completion of five-yearly checks—a move supported by the HCSA's Executive Committee. (Although it should be stressed that the details of how this should best be achieved will not be debated by the HCSA's Council until its meeting on 18 March).

It is the HCSA's view that such a system of revalidation will help root out clinicians failing to keep up with good practice.

In summary, with the arrival of the Bristol heart deaths inquiry, clinical governance and GMC revalidation—the last two of which will introduce annual appraisals of consultants—health managers will soon have at their disposal a raft of effective measures for dealing with and perhaps pre-empting failing doctors.

The prospect of a new contract for consultants—negotiations on which are about to commence between the Government and representatives of the profession—could well add another safeguard. For the new contract presents an opportunity for the guardians of good medical practice—the Royal Colleges—to stipulate what is a safe workload for consultants to undertake.

All these factors paint an optimistic picture for quality control in health care. If adopted in the private sector as well as just the NHS, these measures would preclude the need for the Government to establish a

draconian outside inspectorate, akin to the Police Complaints Authority or the Civil Aviation Authority, as some commentators have mooted for the health service.

There is a danger of overkill in all these moves. Commentators may be right in suggesting that plans for revalidation is a knee-jerk reaction to the events of the Bristol saga, which could have been prevented by checks and balances outside the range of GMC revalidation. Many doctors seem to think so, as evinced by the letters page in *Hospital Doctor* 25 February (page 24) which has the headline "Revalidation is panic reaction to Bristol affair".

It has been said that clinical governance and revalidation are examples of double jeopardy. This is borne out by the fact that the BMA's Central Consultants and Specialists Committee is split over revalidation. For a substantial majority of that committee believes revalidation can be achieved simply through the mechanisms of clinical governance, which will expose the poor performers who can then be referred to the GMC's new performance review committee set up last year to deal with lazy, rude and incompetent doctors.

Establishing an independent inspectorate of hospitals would simply constitute triple jeopardy for doctors, whose rotten apples should already be dealt with under the systems for clinical governance and revalidation yet to take effect.

The feature in last week's *Hospital Doctor* headlined "How to help doctors who underperform" (enclosed)¹ also shows that the mechanisms for dealing with poor workmanship already exist in the NHS. It is merely a question of requiring the private sector to adopt the same methods.

From national newspaper reports today (18 March 1999) on Government plans for an inspectorate of private hospitals, it appears the Government is contemplating the worst of all worlds. For the Government wants a hotchpotch of regional commissions to inspect private residential nursing homes (already outlined in a white paper earlier this year), a new inspectorate for private hospitals, and to keep the private sector outside the remit of the National Institute for Clinical Excellence and the Commission for Health Improvement.

This policy appears to separate the private sector from the NHS, each having separate monitoring mechanisms. Perhaps this is intentional for political reasons. But surely the best way forward is to make the same quality safeguards on stream for the NHS applicable to the private sector?

Another trend in private practice which concerns the HCSA is the private sector's adopting of the "Managed Care" philosophy prevalent in the USA, where insurers attempt to control costs by strictly defining lengths of stay and treatment protocols for every condition for consultants to follow.

The HCSA is anxious that Managed Care should not produce "underperformance" in terms of clinical results as a consequence of consultants being pressurised into premature discharges; for example, inadequate physiotherapy following joint replacement.

Furthermore, there is a need to regulate the standards of Resident Medical Officers in private hospitals, as many private hospitals have RMOs with greater or lesser degree of permanence. Their standards do influence clinical outcomes and their performance can be of concern to consultants living at a distance from the private hospital.

March 1999

APPENDIX 41

Letter from the Director of Intensive Care Services Broomfield Hospital to the Chairman of the Committee (PM 93)

I am writing to you to raise a particular anomaly that relates to treatment of patients who develop a need for intensive care while undergoing private medical care. This is a matter that has exercised me both locally as the Director of Intensive Care at Broomfield Hospital and during my time as Secretary of the Intensive Care Society.

At present BUPA and other large insurers refuse to remunerate NHS units that admit patients for intensive care other than for a limited period of time as part of a planned stay (48–72 hours) after a major operation. They state that there is an agreement that has been made with the NHSE that patients undergoing private medical or surgical treatment who develop an emergency, unexpected need for intensive care can be transferred to NHS facilities and that no further financial liability will be met by them for this treatment. They also refuse to reimburse private hospitals for any unplanned intensive care provided by those few private hospitals that have these facilities. This change occurred about four–five years ago. Prior to that, provided the insurance companies were contacted and written updates of the patients' progress were provided, they would reimburse the hospital.

The vast majority of in-patient private medicine is related to surgical procedures of various degrees of complexity. With all anaesthetic and surgical procedures there is an associated risk of an unplanned major complication (for example serious drug reaction, pulmonary embolus or major haemorrhage after surgery)

¹ Not printed.

requiring intensive care. This risk varies with the individual patient and the procedure. The probability of these events occurring is small but is calculable. I do not refer to poor quality care but to the small residual risk that is present even with the best possible care.

At present in my own particular situation we may be presented with an acute problem which requires immediate intensive care. The expectation is that the on call intensive care consultant is expected to be available to provide immediate stabilising intensive care in the private hospital using NHS equipment to do this and then to transfer the patient to our intensive care unit. These admissions are of course unplanned and may coincide with emergencies that have developed within the NHS establishments to which we are contracted to provide intensive care services. This has caused a considerable conflict of interest. The transfer of a patient from a private hospital to our unit, has caused the cancelling of major elective surgical cases requiring routine post-operative intensive care due to a shortage of beds.

These events are not common however they have a significant cost financially and in terms of NHS hospital facilities. In 1998 only six patients were admitted to the ICU at Broomfield. These patients required 49 days of intensive care at a cost of approximately £85,000 excluding professional time cost. There were also a further 86 days of inpatient stay within the general wards of the hospital following discharge from intensive care. All these patients had been admitted for elective procedures to the private facility. It is obvious that while the beds are occupied by these private patient transfers, elective NHS patients cannot be admitted.

It would seem that the private sector is using the NHS to indemnify itself against a risk which is calculable. There is no requirement for private hospitals to provide intensive care facilities (or purchase these facilities from another provider) and no recognition by the insurers that there is a risk present in any medical intervention. I have no knowledge of, or influence on the activities that go on in private hospitals. The fact that elective procedures are being undertaken without a recognised provision of resources to cope with the uncommon but calculable risk of a major event occurring seems inappropriate. I fail to understand why the taxpayer has to indemnify the private sector for the cost of emergency care that has a direct chain of causation following planned elective medical or surgical intervention. I also fail to understand why the local NHS Trust has to have its working disrupted by the emergencies generated by hospital activity over which it has no control.

My comments will be criticised as being the result of having particular political views regarding private medical care. It is true that I do virtually no private practice but I have no a priori antagonism to private medical care. My major concern is that the NHS is subsidising the private sector to a considerable degree by indemnifying it against a sizeable and calculable risk for which it chooses to avoid payment. If the costs for Broomfield intensive care (I have not included costs of any other transfers to the hospital for coronary care or other ward care) are representative of the Thames Region, then the potential cost to the NHS for intensive care following elective private care is greater than £3,000,000 for this part of Britain alone.

One solution would be that private hospitals carrying out surgical procedures should have a formal requirement to have intensive care facilities or a formal contract for their provision by a local NHS Trust. Insurance companies would be required to reimburse the NHS for intensive care provided as a direct consequence of the initiation of an elective course of treatment. I exclude patients presenting with emergency problems unrelated to current private treatment. The only exception would be private hospitals that promote themselves as providing emergency care.

18 March 1999

APPENDIX 42

Memorandum by MACA (PM 99)

INTRODUCTION

MACA is a leading national mental health charity. It has served people with mental health needs for over 100 years. We are partners with over 50 health and local authorities and housing associations. MACA's core business is the provision of housing with support and care across a wide range of need. It also provides community support to people living in their own homes; respite care; employment training; and advocacy.

SUMMARY OF KEY POINTS

- there must be a realistic balance created between the need to strengthen the protection of vulnerable users of services while avoiding unreasonable demands on private and independent providers, in particular not-for-profit organisations;
- the voluntary sector has a central role to play in delivering services for people with mental health needs. Being independent, it can be innovative and flexible, meet specialist needs and act as a catalyst and partner in developing services;
- the development of specific national minimum standards in all care areas will be a major step forward. However there is a real danger that highly-prescriptive and unrealistic standards will be counter-productive,

- all providers should expect to be regulated and inspected in the same way. The same standards should apply regardless of whether services are managed by the public, private or voluntary sector, or where they are provided;
- a single system of regulation and inspection for all users and services is welcome, but it must reflect the differing needs of each area, eg mental health services, and be staffed by those with expertise in each area;
- the main focus of any system should be measurable and meaningful outcomes based on users' views;
- we recommend that the Government's proposals include compulsory regulation of private domiciliary care agencies, non-care domiciliary services and day care;
- the fees charged to cover the cost of regulation and inspection could have a significant impact on care providers. This is especially true for not-for-profit voluntary sector organisations;
- good practice in complaints handling issued by the Cabinet Office (*"How to Deal with Complaints"*, June 1998) should be the basis of any procedures set up to look at complaints about healthcare outside the NHS.

GENERAL POINTS

1. We approve of the general thrust of the Government's White Paper *"Modernising Social Services"* (Department of Health, November 1998) with its emphasis on promoting independence, improving protection of vulnerable adults and raising standards of care across all healthcare sectors.

2. There needs to be a realistic and sensible balance created between the need to strengthen the protection of all vulnerable users of services while avoiding unreasonable demands on private and other independent providers, in particular not-for-profit organisations.

THE ROLE OF THE VOLUNTARY SECTOR IN SERVICE PROVISION

3. The voluntary sector has a central role to play in delivering services for people with mental health needs. As pointed out in *"Modernising Social Services"* (p20),

"some 80 per cent of adult residential care and 40 per cent of domiciliary care is already provided by the private and voluntary sectors. Many authorities have found themselves able to deliver more responsive services through a mix of public, private and voluntary provision".

4. MACA has also welcomed the Government's "Compact" with the voluntary sector, which recognises its contribution towards a truly inclusive society.

5. Voluntary agencies have a wealth of expertise and experience to offer. They regularly work between the "two cultures" of health and social care. Being independent, they can be innovative and flexible, meet specialist needs and act as a catalyst and partner in developing and facilitating statutory services. They can often also attract different funds and resources. In particular, voluntary sector organisations in the mental health field, such as MACA, can often attract people with mental health problems who are wary of any contact with statutory services.

6. It is not always recognised that the voluntary not-for-profit sector provides many high profile and cutting-edge services, such as advocacy in high-security psychiatric facilities and assertive outreach with hard-to-engage people who the statutory sector has been unable to maintain contact.

REGULATION MONITORING AND INSPECTION/NATIONAL STANDARDS

7. The growth of the contract culture in residential care has added another layer of monitoring, through the purchaser specifying quality measures and the provider's own internal QA system, in addition to the Social Services Department Inspection Unit (SSDIU). From a user perspective, this may not always be helpful. Some residents become resentful of so many different people canvassing their views. There needs to be a way to obtain these views without imposing too much on users.

8. The development of specific national minimum standards in all care areas will be a major step forward. These benchmark standards should ensure acceptable quality and greater consistency of application which is not susceptible to local interpretation. They should also ensure that people have equal access to care, and an assurance of a quality service. At present there is too much scope for local interpretation of standards.

9. However, there is a real danger that highly-prescriptive and unrealistic standards will be counter-productive. These will do little for the welfare of people using services, whether in their own home, a day centre or a residential setting, and they may lead to the closure of many perfectly good services.

10. All providers should expect to be regulated and inspected in the same way. The same standards should apply regardless of whether services are managed by the public, private or voluntary sector, or where they are provided. The only way to achieve this is for a truly independent inspectorate to be created, not one that is simply another arm of local government. We therefore support the establishment of Regional Commissions for Care Standards (RCCS).

GENERAL SOCIAL CARE COUNCIL/COMMISSIONS FOR CARE STANDARDS

11. MACA approves of the registration, regulation and training of all social care workers under the proposed General Social Care Council. It should be recognised, though, that care professionals must have access to local support and proper resources to enable them to do a good job.

12. A single system of regulation and inspection for all users and services is welcome, but it must reflect the differing needs of each area, eg mental health services, and be staffed by those with expertise in each area. It is particularly important that inspectors assessing mental health services have proper training in mental health. At present, SSDIU's too often lack the necessary expertise in mental health matters and try inappropriately to apply standards for the elderly.

THE USER PERSPECTIVE

13. Regulation, monitoring and inspection should be based on minimum standards in which all stakeholders have confidence and which are applied reasonably with a regard to local circumstances. But the main focus of any system should be measurable and meaningful outcomes based on users' views.

14. MACA has welcomed the many references made by the Government over the past two years to ensuring user views are at the heart of service development. In reality, this appears to be harder to achieve on the ground. Expectations spoken of centrally may not always be met. We would strongly support formal, possibly statutory, requirements to involve service users, carers and relatives in discussions about standards and outcomes.

SCOPE OF REGULATION, MONITORING AND INSPECTION

15. MACA supports the proposed role of the RCCS in regulating not just residential and nursing homes, but also domiciliary care.

16. There is a strong argument that, especially for domiciliary support services, mental health service users are in greater need of protection than in residential care. We are concerned that the Government's proposals do not include compulsory regulation of private domiciliary care agencies, and that both non-care domiciliary services and day care appear to be left out of the provisions. We recommend that they should be included.

COSTS/FEES

17. The fees charged to cover the cost of regulation and inspection could have a significant impact on care providers. This is especially true for not-for-profit voluntary sector organisations such as MACA.

18. We agree with Burgner (*"The Regulation and Inspection of Social Services"*, Department of Health 1996) that "the costs of regulation should largely be met through providers' fees, but some part will necessarily be met from public funds". There should be a standard fee set for each type of inspection, with a sliding scale of charges in addition for any work (eg additional visits) deemed necessary by the RCCS. This would be an incentive for providers to maintain high standards.

COMPLAINTS PROCEDURES

19. Users of services should be given information about their RCCS as a body they could complain to, and the RCCS must have a formal procedure for independently investigating and resolving complaints about services. But it is important that service providers are first allowed to try to resolve any complaints quickly at local level, through their own procedures.

20. Good practice in public service complaints handling issued by the Service First Unit in the Cabinet Office (*"How to Deal with Complaints"*, June 1998) should be the basis of any procedures set up to look at complaints about healthcare outside the NHS, and may be used as a benchmark standard against which to judge individual service provider's systems.

21. It is also important that procedures exist in each RCCS to deal with complaints about the regulation, monitoring and inspection arrangements themselves.

APPENDIX 43

Memorandum by British Association of Cosmetic Surgeons (PM 101)

CONTENTS

Item

Summary of main recommendations

Cosmetic Surgery

- What is it
- The role of selection
- History

British Association of Cosmetic Surgery (BACS)

- Membership requirements
- Training
- Relationships
- Role of the General Practitioner
- Cosmetic Surgery and the NHS
- The role of Agents in cosmetic surgery

Promotion of Cosmetic Surgery

Role of Marketing and Advertising

Quality of UK Cosmetic Surgery

SUMMARY OF MAIN RECOMMENDATIONS

The British Association of Cosmetic Surgeons (BACS), on behalf of its members, welcomes the enquiry, by the health Committee into the regulation of private and other independent healthcare.

BACS members applaud the concept of ensuring quality of care and service through effective regulation. They believe that this will further protect their patients and the general public (ie potential patients) from cosmetic providers outside the remit and controls of organisations such as BACS.

The implementation of regulation of both practitioners and organisations is desirable to facilitate quality standards on behalf of the consumer.

The creation of national cosmetic surgery quality standards and protocols, codes of practice, audit of expertise and ongoing training and education.

Any body implementing and enforcing regulation, which should be equal across all aspects of healthcare, must ensure the protection of the rights to practice on an equal basis, for all trained, qualified and experienced practitioners.

Any regulation should stimulate and encourage the integration of cosmetic healthcare in the UK by adopting some of the elements of best practice from the USA. This is particularly relevant with regard to the benefits of liaison and co-operation between teaching hospitals, universities, colleges of practitioners, various representative bodies, educational bodies and fellowships, pharmaceutical companies, the NHS and General Practitioners.

Any new regulations should allow suitably qualified cosmetic surgeons to advertise direct, within normal advertising standards. This will negate the need for the indirect promotion which currently takes place and would facilitate even more knowledge and choice for the GP and patient. It also reduces the impact of the third agency in directing patients.

Efforts should be made by any regulatory body to include the GP in the cosmetic patient process. Perhaps the GP could charge for any advice or referral, or employ a counsellor in their own practice (or PCG) to control the flow of cosmetic patients. This, of course, would have training and cost implications but would help to drive the patient's back to the GP in their role as medical advisors.

The creation of one central cosmetic surgery advice resource with the objective of providing consumers with unbiased, accurate and professional guidance and advice.

On behalf of the British Association of Cosmetic Surgery the membership have instructed the Secretary to draw up the document explaining the present position of cosmetic surgery in the United Kingdom today.

WHAT IS COSMETIC SURGERY

Cosmetic surgery are those procedures whose sole objective is to adjust a persons physical sense of disproportion in order to make them more comfortable with themselves and their self image. Each one of us has a sense of disproportion to a lesser or greater extent. Self image is an important concept to understand in that, it's as dependent on our perception of our physical attributes as it is our capabilities or skills but unlike the latter is stubbornly non-negotiable.

The anecdote of the patient who felt awkward and too tall visited his doctor requesting surgery to reduce his height. The doctor responded by taking him back into the waiting room, and lined him against the waiting patients, and explained that he was not tall and gangly but of average height. The patient beamed with joy and thanked the doctor profusely for his help, but as he left through the door he ducked.

The attention and importance that we give to our self image, clothing, hair-style, cosmetics is increasingly subject to external pressures from the media, cosmetics and clothing companies, travel and leisure industries. It is only a natural development that with the advances in medical sciences there should be a demand to adjust the self-image by surgical intervention. Already we have surgery to repair "unnecessary" injuries sustained in sport or abuse.

Priorities and moralities of cosmetic surgery are often debated at a superficial level, but in truth it demands a much more serious philosophical understanding, we are concerned with values which we perceive as high priority, but are not quantifiable.

The writing of George Santyana—A Sense of Beauty is still one of the most definitive articles on the subject for those looking for further reference.

Cosmetic surgery patients are divided into two major groups:

1. Those patients who really have a disease, injury, or deformity that also needs correction of the underlying condition and rehabilitation's such as burns, cleft palates, congenital deformities. These clearly need to be dealt with by trained specialists who have a special knowledge of the whole disease or rehabilitation process. Where there is a pathological problem alongside a cosmetic need then that patient needs to be managed by a dedicated specialist discipline or in a multi-disciplinary setting.
2. The second group is where there is no underlying disease present, but what is required is purely a technical procedure for correction. It is this second area of surgery that is relevant to this evidence. It is important to understand clearly the concept that the surgery being performed is highly predictable. The result of the surgery is entirely dependent on the technical ability to perform predictable repetitive procedures. These operations by their nature are usually lacking in pathology and it is reasonably easy for a mature surgeon from any disciplinary background to speedily acquire skills to operate competently. They do not require the back up of any particular surgical discipline to extricate from difficulty. Main stream surgical procedures on the other hand are considerably more difficult to manage and all require supervision from the dedicated surgical discipline concerned. A cleft palate problem needs to be managed by a plastic surgeon or paediatric trained surgeon, who understands fully the rehabilitation process and has gained experience in this particular problem. A malignancy needs to be overseen by a specialist who is dedicated to understanding the entire management process. Apart from nasal correction all the other cosmetic procedures are relatively simple, such that it is purely a technical, not an intellectual requirement to be able to perform.

THE ROLE OF SELECTION

There is a particular skill in being able to assess and accurately gauge a person's sense of disproportion and then to be able to understand the expectations and explain limitations to the patient. Not all doctors are able to acquire this skill. It is the ability to be able to correctly select the patient and match the surgical technique that leads to successful surgery. Many competent cosmetic surgeons often state that the most difficult part of their practice is patient assessment, not as popularly believed the surgical technique.

HISTORY

The majority of basic cosmetic procedures have their origins over 50 years ago and have changed surprisingly little in detail. General Surgeons, ENT and Plastic surgeons have been involved for many years. Recently a French Gynaecologist was responsible for developing the lipo-suction technique. The USA is the most advanced country in cosmetic surgery. In the USA there is co-operation involving teaching Universities, Private Sector, and a variety of educational seminars and fellowships. On the other hand some of the most inspired cosmetic surgeons come from South America, where often their basic qualification is limited, and they would have no recognition in the United Kingdom.

Plastic surgery was born as a speciality in the 1940's in particular to deal with the severe burns of injured airman. With the help of the Ministry of Information these burned patients were isolated, in particular from the uncommitted Americans, and miraculous results were claimed. Since then Plastic surgery has achieved remarkable results especially in dealing with congenital abnormalities, certain tumours and burns and major re-constructive surgery.

In the 1970's there was a rapidly increasing demand for cosmetic surgery which was being managed by relatively few poorly trained (in cosmetic surgery) NHS consultants.

This resulted in an escalation in prices and very little innovation or development in technique. At the same time there was an increase in the number of highly skilled and trained surgeons capable of carrying out cosmetic surgery in the UK. Unfortunately many of these trained and skilled surgeons were not recognised by the establishment as some had not achieved the NHS Consultant status or had trained abroad. Many of these surgeons, however, had worked within the NHS in other specialities as consultants, locum consultants, Senior Registrars or SHO's or as an equivalent abroad.

Unfortunately, and as a result of the financial rewards available, some plastic surgeons in the UK have attempted to profit from the increase in demand for plastic surgery.

Whilst this, in itself, is acceptable their efforts to operate a "closed shop" by rejecting other more experienced and sometimes better trained cosmetic surgeons as well as actively promoting against them is both unacceptable behaviour against professional colleagues and not necessarily in the best interests of the prospective patient.

BRITISH ASSOCIATION OF COSMETIC SURGEONS (BACS)

The British Association of Cosmetic Surgeons has a national membership of surgeons practising full time cosmetic surgery in a number of locations throughout the UK.

There are currently 29 active members of the Association who between them carry out between 12,000 and 15,000 cosmetic procedures each year in the UK.

The association handles over 3,000 telephone enquiries each year from consumers interested in information on cosmetic surgery procedures and/or cosmetic surgeons. In addition there are a further 500 media enquiries from the press, production companies, TV and radio stations and talk shows.

The membership of the British Association of Cosmetic Surgeons consists of:

- members who have previously held NHS consultant posts;
- those who have held locum consultant posts;
- surgeons who have previously held senior registrar or SHO posts;
- surgeons who have held consultancy posts abroad;
- surgeons who have undergone specialist training/examinations abroad.

Response to enquiries from the general public for information is usually in the form of literature and if requested the Associations handbook entitled "*Basic Account of Cosmetic Surgery*".

BRITISH ASSOCIATION OF COSMETIC SURGEONS MEMBERSHIP REQUIREMENTS

The Society shall consist of:

- (a) Full Members;
- (b) Associate Members;
- (c) Overseas Members;
- (d) Honorary Members.

Full Membership

(A) Full Membership shall be open to fully registered medical practitioners largely engaged in the practice of cosmetic surgery who are:

- (a) Fellows of the Royal College of Surgeons in the United Kingdom, Fellows of reciprocating colleges or an overseas equivalent; and
- (b) Have a proven competence in an approved cosmetic surgery module;

(B) For the purposes of sub-paragraphs (a) and (b) above the Association recognises the following categories of cosmetic surgical work as being approved modules:

- | | | |
|---|---|--------|
| <ol style="list-style-type: none"> (a) Rhinoplasty Blepharoplasty Facelift Laser/chemical peel | } | Facial |
| <ol style="list-style-type: none"> (b) Dermatological matters; (c) Abdominoplasty; (d) Liposuction; (e) Hair transplantation; | | |

- (f) Gender surgery;
- (g) Aesthetic breast surgery.

ASSOCIATE MEMBERS

Any medical practitioner who in the opinion of the Council, is in sympathy with the objects of the Association or is engaged in work of interest to the Society, shall be eligible for election as an Associate Member.

OVERSEAS MEMBERS

Any medical practitioner who has appropriate accreditation in his own country and who has proven experience in an approved cosmetic surgery module.

HONORARY MEMBERS

Honorary Membership may be offered by the Council to any medical practitioner who in its opinion has performed notable service to either the association or the cause and development of cosmetic surgery generally.

TRAINING

There is no comprehensive training in cosmetic surgery. Many consultants are appointed without even having performed any cosmetic operations at all. They only start to learn the techniques after they have taken up their consultant appointment. Throughout cosmetic surgery there is a culture of secrecy and parochialism even amongst surgeons in a similar grouping. To a certain extent these anxieties are understandable. Cosmetic surgery is purely a matter of technique and is not dependent on patronage or back up training within any particular speciality. Some of the best training in cosmetic surgery is available in the USA where very detailed courses are arranged and preceptorships and fellowships are available. Perhaps in the interim we should be looking for surgeons to have undertaken some of their training in the USA.

Nasal contour operations (rhinoplasty) are the most difficult operations and are taught in ENT centres. Most ENT surgeons now have the opportunity to be taught nasal cosmetic operations whilst in training. This has been mainly due to one surgeon, Mr T R Bull who, during the past twenty years, has arranged training programmes with some of the most acclaimed surgeons in the field, predominantly from the USA.

Many surgeons have travelled to the USA where there are many excellent training courses and facilities and brought back their expertise to this country. The British Association of Cosmetic Surgeons has often invited surgeons from the USA to teach its members and, as a result, has developed many ongoing professional relationships.

When the new technique of laser resurfacing was introduced into the UK in recent years the Association invited the most experienced exponents around the world to demonstrate and train our members in this modality to instruct its members including Plastic, ENT, ophthalmic surgeons and dermatologists.

The training for cosmetic surgery is also bedevilled by the secrecy and jealousy alluded to earlier. Even the most senior consultants are reluctant to share their expertise with their fellows even in the same speciality. Some junior surgeons in training, secretly attend full time cosmetic surgeons to gain experience. The training in cosmetic surgery is necessary for all the same reasons as other surgical specialities but especially to learn and develop new and improved techniques. Parallels can be drawn between the conversion course that a civil pilot undergoes when being transferred from flying a Boeing to an airbus. It is clearly not necessary that a civil pilot have all the training of a RAF pilot flying tornadoes with weapon navigated system etc.

Only a few cosmetic surgeons perform the whole range of cosmetic surgery. Many restrict their surgery to a few modules or areas of surgery as identified by the Association.

ROLE OF GP

The role of the GP in the provision of cosmetic surgery has been sadly and increasingly marginalised in recent years and needs to be redressed.

In spite of constant high profile advice by the GMC and BMA for the patient to attend their GP for first advice on cosmetic surgery, a large number of patients have decided not to do so. That patient's viewpoint must be taken into account.

The inspector of Police does not feel that he should unburden his problems of baggy eyelids or a hooknose to his GP. In many ways he is in the same position of the patient who has a sexual or fertility problem that is now already exempt from a prior visit to his GP.

The lady seeking a face lift operation will have already read many articles which appear in a wide range of publications from the *Financial Times* to the *Sun* newspaper. She would have avidly watched many TV. programmes on cosmetic surgery. Most channels regularly devote time to the subject often with explicit operative detail balancing both complication and success. She will have already spoken to experienced friends and have researched both the surgeon and facilities. This patient is clearly not inclined to unburden her problems to her GP who possibly knows far less about the subject. The GP, anyway, is only able to recommend her to the local NHS part time consultant on an approved list. The consultant may have had little training in the subject but may be considered “good” because he performs the most amazing surgical reconstructions for cancer.

The cosmetic surgery patient is usually far better informed on matters of technical detail and surgeons than the average patient seeking, for example, a gall bladder operation.

The GP has been increasingly required to refer their patient to the shortest NHS waiting list or the local restricted private hospital network (private insurer driven and directed). They have not been encouraged or rewarded to research the best service available, in his (or her) opinion in order to give the consumer a better choice.

There is a case, perhaps even an ethical imperative, for the general practitioner to accept a greater role in advising patients of alternatives across the whole spectrum of medicine on a best interest basis. With increasingly sophisticated managed medicine both in the USA and the UK but with limited budgets and tight financial controls, there is clearly a conflict of interest with patient needs. This is increasing the pressure on the purchaser/provider relationship whether public or private sector. The patient needs easily accessible and helpful advice on the availability of best practice irrespective of local availability or cost. This enables them to be able to make an informed choice.

COSMETIC SURGERY IN THE NHS

The majority of cosmetic surgery carried out in the NHS is:

- Varicose Veins—General Surgeons;
- Protruding ears in children—Plastic Surgeons/ENT Surgeons;
- Macro mastia (pathologically enlarged breasts)—Plastic Surgeons;
- Orthognathic surgery (surgery of the jaws)—Oral Maxillofacial Surgeons.

Other areas of cosmetic surgery are excluded from NHS provision. As a result the consumer must at present search for advice or information from a variety of sources such as:

- Magazine;
- Newspapers;
- Television/Radio;
- British Association of Cosmetic Surgeons;
- British Association of Aesthetic Plastic Surgeons;
- Third party agencies (via advertisement);
- Yellow pages.

The lack of one central recognised advice resource for cosmetic surgery able to give accurate, unbiased and professional advice to the consumer has enabled unprofessional practice to develop and affect the reputation of this whole area of serious surgery.

Within the NHS there has always been a pool of highly trained but poorly paid surgeons with limited career prospects. As cosmetic surgery developed they became aware of the potential of increasing their earnings by undertaking these relatively simple procedures. At the same time some marketing oriented entrepreneurs involved in developing cosmetic surgery agencies or centres who saw the increase in demand also saw the potential for enticing these surgeons to undertake work on their behalf usually with a percentage based remuneration (typically 20–25 per cent of the total fee).

There was a handsome profit to be made after surgeon and anaesthetist fees, expenses, hospital and marketing costs had been debited. A small minority of hospital consultants reacted vociferously against these new competitors labelling them cosmetic cowboys. They were often willing to give expert evidence in the courts or adverse interviews to the press. It is interesting however that these same consultants so concerned at the public's fate never took the altruistic, and probably, the shrewd business step of reducing their high professional charges and therefore eliminating the margins from their business competitors. This would have made it less attractive to the “cowboy” element who would have then been dissuaded from cashing in on this buoyant market.

There was and still is a strong element of demarcation dispute in the cosmetic surgery world (reminiscent of the woodworkers and pipe fitters closed shop disputes). In the NHS where there are not such financial incentives the relationship between specialist groups is much more relaxed.

A quarter of a century on many of those surgeons operating week in and week out have now matured to be some of the most experienced and accomplished surgeons in the country. They have developed standards and protocols and a high level of care for their patients. They have invested in continuous education and are beginning to investigate effective audit procedures. Most of the less reputable agencies have been savagely and quite rightly eliminated. Now the major providers are increasingly concerned with compliance. These major cosmetic providers have recognised that they have to provide an increasingly relevant service benefit to the community, if they are to benefit from the ever vigilant consumer.

THE ROLE OF AGENTS IN COSMETIC SURGERY

It is a general impression within the international field of cosmetic surgery that the cosmetic patient often feels the need to see an intermediary prior to seeing their surgeon. It is normal practice for a large cosmetic surgical practice in the USA to employ specially trained staff in their clinics to interface with the patient. The patient, evidently, feels much more comfortable with this relationship.

There are two main groups of intermediaries:

1. Agents who provide counselling and an introduction to cosmetic surgery. The larger of these agents have become major providers. It is always a concern that the patient seeing an intermediary will be "sold to" or persuaded to have unnecessary surgery and that he is paying an unnecessarily high premium for this benefit. These concerns may be balanced by the fact that most cosmetic patients are extremely well informed, far better than the general round of surgical patients. It also has to be understood that it is incumbent on the cosmetic surgeon that he follow normal professional protocols and issues unbiased professional advice prior to surgery both to avoid legal consequences and to ensure best patient care. There is already debate regarding the lifting of restrictions relating to the advertising of the medical profession and information technology is driving this debate forward whilst further helping the patient with their choice.
2. We must also include, within the main providers of cosmetic surgery, BUPA and PPP. Both these companies own hospitals and use their insurance arm as an agency to drive patients into these hospitals. Cosmetic surgery is not covered by insurance but loan packages are available or the corporate body or the hospital itself advertises cosmetic surgery. We are particularly concerned generally, that health insurers have the opportunity and power to influence the surgeon, the type of procedure, the prostheses used, level of drugs and surgical facility, and the level of care a patient may or may not receive.

PROMOTION OF COSMETIC SURGERY

In the early post war years an eminent surgeon would utilise Red Cross workers to promote his/her practice. The workers would travel around giving lectures to Women's Institutes about the surgeon's particular area of speciality.

In the 1960s a group of Plastic Surgeons allowed magazines to promote their expertise by judicious articles which led to a celebrated case in front of the General Medical Council.

In the 1970s there was little demand for cosmetic surgery, but that which did occur was mainly performed by Plastic Surgeons who had no special training in techniques, but established the high charges and often had waiting lists.

In the 1970s there occurred a unique event in the United Kingdom. This was the development of marketing organisations contracting with surgeons to do cosmetic surgery. To fully understand this phenomena it is necessary to understand the career structures within the NHS. Essentially the National Health Service has been manned by Consultants who achieve their position by a combination of expertise and patronage. It is not always the most able who become Consultants, and also it has opened up areas of discrimination. In the US a surgeon requires board certification which he achieves by entering a programme which culminates in combined examination and skills assessment. He can then go on to attain additional fellowships through the links developed between universities and the private sector. In the UK however there is no formal training in cosmetic surgery however once accredited a surgeon can promote their practice.

In fact there were too few Consultants to meet demand which meant that the majority of work being performed in hospitals was by so called junior doctors in training. This training may often be as long as 15 years without any significant career prospects. Surgeons would often perform major operations standing in for the Consultants, and at many times with little supervision. It has been estimated that in some hospitals at least 90 per cent of out of hours work was performed by doctors in so called "training".

Essentially employment of a doctor was in the hands of a Consultant, he was able to support or reject the career prospects of a younger doctor, almost at times by a whim.

The frustration of these low paid doctors, after many years in service was released when marketing organisations approached them and enabled them to be employed outside the NHS performing relatively simple procedural operations which had no pathology or disease and were highly repetitive, the success rate was therefore extremely high.

The agent would often pay the surgeon approximately 20–25 per cent of the total fee taken which gives some idea of the margins that are available in this type of surgery.

The development of these surgeons met with extreme hostility, especially from the Plastic Surgeons who saw their livelihoods threatened. As a result they commenced a continuous hostile attack, threatening the doctors career, threatening the doctor with hostile expert evidence and also using the media and the rest of the profession to create a negative and adverse perception.

It must be understood that the vast majority of Plastic Surgeons were not involved in this conflict which was nicknamed the “Cosmetic Ice cream War” (after the gang warfare in Glasgow between rival ice-cream sellers).

The use of agents to channel patients certainly broke custom, whether it broke ethics is debatable, certainly there must be a question mark over a non-medical person obtaining a pecuniary benefit from referring a patient.

HOW MUCH HARM HAS REALLY BEEN CAUSED?

The majority of patients’ considering cosmetic surgery have been bombarded with information on TV, journals, and newspapers, and are probably the best informed of all patients attending for medical advice. For reasons unknown a large number of patients do like to talk to an intermediary before seeing their surgeon when it comes to cosmetic surgery. This may be the carefully chosen secretary or administrator in a hospital or consultant suite or a beautician who associates with both plastic and cosmetic surgeons.

ROLE OF MARKETING AND ADVERTISING

Strict guidelines on advertising professional services have been in force for some time and act to protect the consumer from misrepresentation. There is however, a great deal of misunderstanding regarding the status and nomenclature relating to various practitioners:

- Who is a consultant, a surgeon, a practitioner?
- Who is experienced or trained?
- What level of experience and training qualifies someone to operate or call themselves a “consultant” or “surgeon”?
- Is it the title they may hold or have held in the NHS or elsewhere which “qualifies” them or is it their level of expertise, number of operations performed, courses undertaken or experience gained.

The cosmetic patient is the most critical of all surgical patients and with the help of the media has already done much to eradicate unacceptable practice in cosmetic surgery. The British Association of Cosmetic Surgeons believes that constant vigilance must be maintained and the vulnerable protected.

For the modern cosmetic surgeon it is mandatory to take the most detailed history, follow protocols, explain the surgery, risks and reasonable expectation to safeguard both themselves from litigation and the patient from dissatisfaction with the outcome.

The surgeon is currently dissuaded from operating on the over persuaded patient or to be involved in pressuring the patient by the constant threat of litigation, the use of which is becoming more easily accessible and of interest to consumers.

The major cause of dissatisfaction from cosmetic surgery is not so much a failure in surgical technique as a failure of the surgeon to bond with the patient and to identify with a realistic expectation.

Major surgical mishaps do occur but there is no evidence that these are greater than in the rest of surgery or that any particular group of surgeons are better trained or equipped than another. The quality of cosmetic surgery in this country is extremely high and this is consumer driven. The patient is well informed, highly critical and has the sympathetic backing of the judiciary and media. If the same standards were applied to the rest of surgery it would without doubt improve the level of service to consumer/patients and force consultants and surgeons to be more “customer” focused.

In recent years there has been high profile interest over the dangers of silicone breast implants and the alleged high incidence of secondary repair operation for cosmetic surgery within the NHS.

Such was the level of public concern that Parliament demanded official investigation.

In the case of silicone breast implants and in spite of dramatic media coverage of the issue and after detailed investigation silicone was absolved.

With regard to the referral to the NHS for repair of private cosmetic surgery the investigation found the number of cases referred was negligible. Many cosmetic operations require minor secondary adjustment which although minor are demanding. It has been a common practice for consultants in the NHS to perform minor adjustment surgery on their private patients within the NHS.

The price for cosmetic surgery is universally high. This may be partly explained not by the technical skill of the operation but rather by the level of risk of dissatisfaction for this type of surgery. The majority of patients who are dissatisfied with surgery have not had a failure in surgical techniques as much as a failure

in meeting their expectations. Every cosmetic surgeon from whatever background would have experienced the patient who has a belief that their life has been “ruined” but in reality has a relatively minor disproportion. The true art of the accomplished cosmetic surgeon is their ability to be able to select and identify the patients sense of disproportion and then adjust it by relatively simple surgical technique. The surgical techniques of main stream surgery are immensely complex and difficult when compared to cosmetic surgical techniques. On the other hand the selection of cosmetic patients in contrast to main stream surgery is much more difficult.

It is also true that society is willing to pay more for aesthetics. We all pay a high premium for different styles of car. Cosmetic surgery is also usually charged for on a fixed cost but in many operations there is a requirement for secondary revision and this is usually explained to a patient prior to the operation. Of course this secondary revision is built into the total fee.

QUALITY OF COSMETIC SURGERY IN THE UK TODAY

Costmetic surgery requires a very high standard of detail in protocol, explanation, proposed action taken and justification. The margin allowed before criticism is small. This leads to a very high standard of surgery in the UK today well above the average mainstream surgery that is not under such intense consumer scrutiny.

The main reason for adverse outcome is a failure to meet patient expectation due to a failure of selection rather than technique. Perfection in cosmetic surgery is rare. The major adverse outcome is probably not as great as the media would lead us to believe. Cosmetic surgery is a high profile subject with both the public and media. Full time cosmetic surgeons say they do it best because they do it every day of the week and have the most experience. The part time consultants tell you that although they do fewer cases they have far better qualifications. Plastic surgeons say they do the best breast reduction, the general surgeon the best augmentation, the ENT surgeon will claim credit for the best nasal contour operations whereas the answer is probably that there is no special group that does it best, just talented surgeons in each. It is recommended however that we obtain better information on this with the implementation of meaningful and controlled audit and evidence of continued education. Both these areas are being actively promoted and pursued by the British Association of Cosmetic Surgeons.

The patients’ interests as the consumer, are best protected by keeping a broad base of surgical expertise and as long as those safeguards necessary to ensure codes of practice for training and audit are in place. The cost of cosmetic surgery has significantly declined in recent years, at the same time the quality, innovation and range of cosmetic surgery procedures has increased. It is equally true that there is some evidence that some of the less careful full time cosmetic surgeons have associated with less scrupulous marketing organisations. It is not their surgical skill which is the problem but their allegiance to the selling and marketing ethic rather than the concept of patient care being of prime importance.

It is to the following concepts that the British Association of Cosmetic Surgeons members subscribe and would wish this committee to address:

- High quality patient care;
- Meaningful and controlled audit;
- Value for money services;
- Continuous training;
- The development of recognisable standards.

APPENDIX 44

Letter from Head of Public Affairs, the Advertising Association, to the Chairman of the Committee (PM 103)

The Advertising Association is a federation of 27 trade associations representing the UK advertising industry in its entirety—advertisers, agencies, the media and support services. Whilst we understand that the Health Select Committee’s current inquiry into private medicine is primarily concerned with professional regulation, we were interested to note that some witnesses have raised the issue of advertising—particularly by private cosmetic surgery clinics.

For your information, therefore I am pleased to attach a briefing paper on the advertising industry’s position on this issue. This is in advance of the Committee’s meeting this Thursday, 22 April, when the Advertising Standards Authority (ASA) and other witnesses will be giving oral evidence. Our briefing paper makes a number of important points.

Firstly the UK’s system of advertising regulation is extremely effective. The non-broadcast sector, which is where virtually all cosmetic surgery advertisements appear, is policed by the ASA. Its research reports that the overall compliance rate with the codes of practice is nearly 97 per cent.

With regard to cosmetic surgery advertising, we understand that over the last three years 76 per cent of all complaints have originated from a single source. The ASA has examined these complaints, discussed them

with the complainant and, where justified, has taken action and received written undertakings from several private clinics that misleading statements will no longer be used in their advertising material.

Finally, the advertising industry shares everyone's concern when patients are maimed, dis-figured or misdiagnosed at the hands of private clinics. However, it firmly believes that advertising is not the cause of this problem and, therefore, that further restrictions on advertising will not eradicate this problem. The problem of patient harm in fact stems from under-qualified individuals practising as cosmetic surgeons in the private sector. The solution, as acknowledged by the topic of the Health Select Committee's own inquiry, is to introduce a system of professional regulation into this sector, which has hitherto lacked any such control.

I hope that you find the attached paper of interest, and would be pleased to address any queries you may have on this or any other matter concerning advertising.

20 April 1999

Memorandum

1. THE ADVERTISING ASSOCIATION

The Advertising Association (AA) is a federation of 27 organisations representing the media, advertisers, agencies and support services. It is the only body which speaks for all sides of an industry currently worth £13 billion per annum. Our remit can best be summarised as to protect and promote the rights, responsibilities and role of advertising in the UK and to provide a common voice for the industry.

The current inquiry by the Health Select Committee pertains, we understand, mainly to professional regulation; however, we were interested to note that a number of questions have been asked relating to advertising, particularly advertising by private cosmetic surgery clinics. In addition, we note that the Advertising Standards Authority (ASA) and a campaigner well known to the AA, Mr Mohammed, have both been called to give evidence before the panel on 22 April.

With these facts in mind, the AA felt a brief note from the main advertising trade association might be of some assistance to committee members. All parts of the industry—advertiser, agencies and the media—have a long-term interest in protecting the freedom of commercial speech by upholding its probity. Thus the need for consumer protection and ethical standards is recognised across the business and has been supported by the industry for more than 40 years.

2. ADVERTISING REGULATION

In the UK there is a combination of statutory and self-regulatory control. These are often debated as alternatives. In our view it is not an “either/or” question; the real issue is the role and relationship between the two. There is a genuine role for “over-arching” framework legislation that defines the parameters in which self-regulation operates. The fact that the Codes are flexible and are interpreted in the “spirit as well as letter” are key operational strengths of the self-regulatory process. Legislative back-up adds weight, authority and an ultimate sanction in the form of the Control of Misleading Advertisement Regulations 1988.

In the particular sector of relevance to the Select Committee, cosmetic surgery clinics, the majority of advertising is carried in non-broadcast media and thus subject to self-regulatory rules administered by the ASA. We have confined ourselves to a consideration of this sector of the regulatory regime although we would be happy to provide information about regulation in the broadcast media should this be of use or interest to the Committee.

2.1 *The Committee of Advertising Practice (CAP)*

The Committee of Advertising Practice (CAP) is the industry body responsible for writing and enforcing the British Codes of Advertising and Sales Promotion (the Codes). Constituent members include representatives of all sectors of the advertising industry.

In addition to writing and reviewing the Codes, CAP members are responsible for enforcing its provisions amongst their own members; they provide a number of sanctions that may be used against those who break the rules.

Finally, CAP provides a free and confidential guidance service for advertisers, their agencies, the media and others.

2.2 *The Advertising Standards Authority (ASA)*

Independent of both the advertising industry and government, the ASA's work is funded by a small levy on display advertising and direct mail expenditure, this levy is collected by a separate body, the Advertising Standards Board of Finance.

The ASA's remit has been defined as being to protect the public by ensuring that the rules contained in the Codes are followed by everyone who prepares and publishes advertisements.

The ASA can therefore be relied upon by the consumer to ensure that advertisements comply with the rules, to uphold justified complaints and to carry out research into code compliance.

2.3 *The Rules*

Advertising in this sector, in common with all advertising, must be decent, legal, honest and truthful. All advertisers must be able to substantiate claims made and are prohibited from exploiting any lack of expertise on the part of the consumer. Rules relating to whether or not an advertisement is misleading (either by inaccuracy, ambiguity, exaggeration or omission) are also backed by the ultimate sanction of the Control of Misleading Advertisement Regulations 1988.

Over and above the general provisions of the Codes, which are applicable to all advertising in the non-broadcast sector, cosmetic surgery advertising is also subject to specific provisions relating to "Health & Beauty Products and Therapies". There are also 19 specific help notes published by CAP. These have been widely publicised and made available to advertisers, agencies and the media in order to assist them in determining the acceptability of advertising prior to publication.

2.4 *Compliance*

The AA is aware of a small group of single issue campaigners, led we believe by Mr Mohammed, who are rightly keen to ensure high compliance in this sector. However, in the context of any discussion about compliance, it is worth bearing in mind that approximately 30 million press advertisements and 3.8 billion items of direct mail appear in the UK every year. Expectations about compliance rates should be seen in this context. It is unrealistic to expect 100 per cent compliance in any sector and it would be unfair to penalise the vast majority who do abide by the rules because of a very small minority who do not.

Having made this point, we are proud of the high rates of compliance in our industry. The self-regulatory system delivers compliance of close to 97 per cent in posters and the press. Whilst we are all able to point to specific examples of advertisements that may have fallen foul of the rules, the question remains: what other system could deliver 97 per cent compliance?

3. COSMETIC SURGERY ADVERTISING: THE ISSUES

We understand that, over the last three years, 76 per cent of all cosmetic surgery complaints to the ASA have originated from one source. Whilst we appreciate the commitment and determination of single issue campaigners, we would suggest that this fact alone illustrates that this is not an area of widespread consumer dissatisfaction.

Since we are aware that Mr Mohammed has been called to give evidence before the Committee, we hope the Committee will find a brief explanation of his contact with our organisation useful. We have also spelt out what we understand to be his concerns.

Mr Mohammed has been in touch with the AA to express his concerns about what he regards as the failings of the regulatory system in relation to cosmetic surgery advertising. In summary, he feels that the ASA has been unable to enforce the rules and that as a result a number of clinics have been able to publish misleading advertisements even after they have been found to be in breach of the Codes.

The majority of complaints received from Mr Mohammed and others relate to the misleading use of terms such as "consultant" or phrases such as "highly qualified surgeon". Evidently, the factual basis for an advertisement must be sound and portrayed in such a way that it is not misleading to the reader. No practitioner should be able to mislead a patient into believing that he/she is in qualified hands if that is not the case. We believe that a number of Mr Mohammed's complaints have been upheld in this area.

The ASA has discussed these cases with Mr Mohammed and taken action in those instances where action was justified. In particular, the ASA has sought and received written undertakings from several private clinics that the misleading or erroneous statements will no longer be used in their advertising material. We are satisfied that they have acted swiftly and effectively to all but stamp out non-compliance in this sector. It is our understanding that the ASA will continue to monitor this sector closely and act where necessary and justifiable.

However, we are concerned that this concentration on advertising is tangential to the real problem in this sector; namely the total lack of adequate professional regulation. The advertising industry is, of course, appalled that patients may be ill-treated, mis-diagnosed, disfigured or injured at the hands of private clinics. However, we believe that it is the lack of relevant or adequate medical/professional regulation or experience that is the root cause of these tragic incidents and not the fault of advertising. We have discussed this with Mr Mohammed on a number of occasions and he has agreed with us that better and more stringent professional regulation would be the most effective solution to this issue. Policy decisions relating to the regulation of private medicine should be directed at the cause of the problem and not the symptoms.

Whilst we cannot pretend to have expertise in the field of private medicine regulation, we understand that there is no legal requirement for those performing cosmetic surgery operations in private clinics to have relevant qualifications. Moreover, we believe there to be no system of checking that these practitioners are qualified, nor sanctions against those who practise cosmetic surgery without such qualifications.

Further restricting advertising in this area will do little if anything to attack the root cause of the problem. Whilst private clinics do use advertising to target potential patients, the vast majority of this advertising is not in any way misleading.

The most effective solution is to tighten up professional regulation and thus eradicate the problem at its source. This would ensure that all patients could have confidence in the abilities of those they trust to carry out cosmetic surgery and would ensure that there is a factual basis for the claims made in subsequent advertising material.

4. CONCLUSION

In conclusion, we recognise that there have been occasions in the past when advertisers have mistakenly or deliberately used misleading phraseology in their advertising copy. We believe that ASA has worked effectively and proportionately to ensure that non-compliance is all but stamped out. We therefore believe that further restrictions on advertising would be unjustified and ultimately ineffective. Indeed, any such policy would do little to address the root cause of the problem of injuries, mis-diagnosis and poor quality patient care in the private sector. The most appropriate and effective solution is more stringent medical/professional regulation.

April 1999

APPENDIX 45

Extract of supplementary Memorandum by Mrs Joan Morton Chairman National Nursing Homes Regulation and Inspection Advisory Group (PM 105)

Further to the Clerk of the Committee's follow up questions on the evidence session on 25 February 1999, I enclose the responses to the specific questions raised by the Committee with supporting evidence.

Copies of the questions were sent to each Health Authority Registration & Inspection Unit and out of the 100 Health Authority Units 51 replies were received within the given time scale. Apologies were received from other Units as their key personnel who deal with the registration and inspection of the independent acute sector were on Easter holidays and some do not have acute sector premises registered at the present time.

I am submitting the responses in the order of the questions as put to me in your paper, with specific quotes from respondents.

PARAS 4-6

- Health Authorities in general do not address clinical issues in their registration and inspection function and this stems from the lack of specific powers under the Registered Homes Act;
- How was the issue of confidentiality dealt with in these cases?

CLINICAL

Of the 51 respondents, 27 stated that they followed up clinical issues. Three of the responses do not have acute independent health care premises registered.

Quotes

"I do address clinical issues in inspection reports. Not to do so would render the purpose of inspection useless. I am amazed that evidence to the contrary was presented to the Committee"—*Camden and Islington Health Authority*.

"Certainly from our experience we would dispute the claim that clinical issues are not addressed during the registration and inspection of these premises"—*Leeds Health Authority*.

"Clinical issues relating to individual patient care are not specifically covered unless, of course, a problem is identified or a complaint is made. Systems and frameworks underpinning the clinical care are explored and reported through the routine inspection report publishing arrangements. The

consultant member only in the Inspectorate Team would have access to clinical records. They would also inspect the arrangements in place for clinical audit”—*Morgannwg Health Authority*.

“Reports are on file in relation to both acute hospitals and mental illness services which focus on clinical and direct care standards. Nursing Home Inspectors readily access any patient records and medical records are examined by a doctor authorised to inspect”—*East Surrey Health Authority*.

“With reference to registration and inspection functions in relation to addressing clinical issues, in general I address these matters under Regulation 7(4); 12(1)(o); 12(1)(p); 12(1)(d); 12(1)(k) and 12(1)(n)”—*Kingston and Richmond Health Authority*.

Please see enclosures A–D¹

CONFIDENTIALITY

“Clinical issues are addressed in Gloucestershire’s report but generally not specifically relating to one resident. If there is an issue that relates to one patient/resident it is anonymised”.

“As nurses, we access care plans and clinical pathways. Our medical advisor accesses medical records, where appropriate. Confidentiality is as per UKCC and the Registered Homes Act”—*Lambeth Health Authority*.

“The patient concerned is not identified in the report and the issues may be discussed in greater detail in a separate letter to the registered persons”—*East Lancashire Health Authority*.

Could you comment on Health Authority access to patient records?

The Statutory Instrument 1984 No. 1578, Nursing Homes and Mental Nursing Homes Regulations 1984, Regulation 10(3) states:

“Nothing in this Regulation authorises any person, other than a medical practitioner in the service of the Crown, or a Health Authority to inspect any clinical records relating to a patient in a home”.

The above is the authorisation for a medical practitioner to inspect the clinical records. With regard to nursing notes, these are inspected by Nursing Home Inspectors.

An alternative would be to seek the permission of the individual patient and ask them to share with the Inspectorate the information held in their medical notes, if they so wished, in accordance with the Access to Personal Files Act 1987.

Examples of Investigation—following a complaint about an episode of treatment in the independent acute sector

Of the 51 respondents, 15 stated that they had carried out investigations/complaints. The majority of these being in single figures for a 12 month period. A number of these are from registered acute mental health nursing homes.

The following quotes have been anonymised for the purpose of confidentiality:

“A patient complained about the lack of information received concerning a termination of pregnancy. This issue has now been addressed and all clients are now provided with written information specifically about all aspects of care in this particular clinic”

“A complaint received re a query post-operative death. This was investigated as any other complaint under the Registered Homes Act. The outcome was no negligence from the management/nursing aspect”

“Areas re complaints were: inappropriate placement; monetary issues/abuse of personal allowance; discrepancy of medication to the detriment of the patient by practitioners; ? withholding medication and utilising for own personal use”

“Examples of complaints dealt with in respect of clinical care were about inconclusive results of a smear test and follow up action taken; delaying carrying out an operation once the patient had been anaesthetised because a surgical instrument required for the procedure was not available.

Checked during inspections and reported is information on numbers of medical emergencies which arise and records in respect of complications following surgery”

“A recent inquiry was held at—Health Authority to investigate issues associated with an apparent intra (peri) operative event in a day surgery clinic registered under the Registered Homes Act. This

¹ Enclosures not printed.

was jointly set up by the Health Authority and the purchasing Trust who had contracted to use the facility for a waiting list initiative.

A similar arrangement is being effected in relation to a recent series of apparent untoward events in another provider hospital. We have had, in one instance, professional discussions relating to resuscitation policy”.

Please see enclosures E, F & G

Evidence of matters pursued with providers (not included in open reports)

Of the 51 respondents, 14 stated that most issues would be included in the report or sent under separate cover where it was important to give greater clarity to the person registered to address the issues.

Quote

“Any issue which may have a business sensitivity eg developments.”

“Any investigation that requires follow up by other professionals and meetings with the persons registered remain out of the public domain, eg individual patient assessments.”

“Issues relating to individual clients.”

Please see enclosures H & I

RE PARAS 51–55

- Would you be good enough to confirm, perhaps following enquiry to your representative members whether or not it is standard practice for each registration unit to know the name and speciality of every clinician who is employed by, or has admitting rights to, independent hospitals or registered clinics in their area?

Of the 51 respondents, 25 stated that they either held the information or it was available to them at the time of the inspections.

Quotes

“North Staffordshire maintain a contemporary list of all clinicians employed by, or who have admitting rights to independent hospitals and clinical areas.”

“Herefordshire Nuffield Hospital contracts with locally known consultants and thus registration problems would be known to them. The RMO’s are employed through an agency that takes out all references. The references and CV’s are then checked by the hospital and available for inspection.”

“To be granted admission rights each clinician must hold a substantive consultants post within their speciality in the NHS”—Morgannwg Health Authority.

“It is the requirement of this Health Authority that the names of all medical staff in acute units are submitted to the Registration Officer. Details to include GMC and Medical Defence Union details of medical qualifications. The onus is placed on the person in charge in accordance with Section 25(1)(f) to ensure that all medical staff are appropriately qualified to provide medical care to patients. At inspections, a check is carried out to ensure the person in charge is fulfilling their responsibility and carry out spot checks with the GMC. Receive all General Medical Council certificates from all medical staff and spot check with the GMC as well as a review system for admitting rights”—Barnet Health Authority.

“Further to our meeting today and in particular the discussion about the Medical staff employed at . . . I write to confirm the purpose of our requests for CV’s from your medical staff.

Under Regulation 12(1)(a) Statutory Instrument 1578, registered facilities must provide adequate professional and technical staff. Section 25(1)(a) of the Registered Homes Act requires that persons employed, or proposed to be employed, must be fit persons. Under these provisions it does not exempt any groups or disciplines and, therefore, medical staff, are subject to the same scrutiny as nursing staff.

In helping us to decide if the Act and Regulations were being complied with I can confirm that the information provided by the medical members was measured against guidelines from the Royal College of Psychiatrists and we were satisfied that you had the appropriate grades of staff employed at the hospital.

I hope this is of some assistance in clarifying the matter for your medical staff”—North Yorkshire Health Authority

Please see enclosures J1 & J2

Is any check made by registration and inspection units that they receive, as a routine, copies of "alert letters"?

Of the 51 respondents, 33 stated that they received copies of alert letters and distributed them to registered premises—one was not sure that they were receiving all alert letters. It appears to be in patches throughout the country.

The next NNAG meeting is on 3 June 1999 and this important issue will be on the agenda.

PARA 99

- A doctor as the person registered or person in charge of a nursing home prescribing and continuing to care for their own patients.

I enclose for your information a copy of:

- The General Medical Council Professional Conduct and Discipline Fitness to Practice, April 1992—K;
- Correspondence between Hull Health Authority and Yorkshire Regional Legal Department—L;
- A letter sent out by Hull Health Authority to all homes where doctors have a financial interest in nursing homes—M.

We have used this information locally when registering a doctor who is to be the person registered or person in charge of a home.

This would be in respect of the "fitness" of the person registered/person in charge, and the ethical issue of a doctor having a vested interest in a business.

Until recently in North Yorkshire we had two medical persons registered with regard to homes in the area, but both doctors, by agreement, did not have admitting rights. Either partners, or another practice, undertook the care of the patients within their premises.

This is not necessarily the practice throughout the country.

I enclose for your information a statement of reasons for the closure of a private hospital from Leeds Health Authority which was granted and not appealed against—N.

I hope the above is of assistance to you but please do not hesitate to contact me if you require additional information.

21 April 1999

APPENDIX 46

Memorandum by Human Fertilisation and Embryology Authority (PM 107)

THE HFEA: AN INTRODUCTION

1. The Human Fertilisation and Embryology Authority (HFEA) was created by the Human Fertilisation and Embryology Act 1990 and began operating in August 1991. Primarily a regulatory body, the HFEA's principal tasks are to licence and monitor those clinics that carry out *in vitro* fertilisation (IVF), donor insemination (DI) and human embryo research. The HFEA also regulates the storage of gametes (sperm and eggs) and embryos. The HFEA's other statutory functions are:

- To produce a Code of Practice which gives guidelines to clinics about the proper conduct of licensed activities;
- To keep a formal register of information about donors, treatments and children born from those treatments;
- To publicise its role and provide relevant advice and information to patients, donors and clinics; and
- To keep under review information about human embryos and any subsequent development of such embryos and the provision of treatment services and activities governed by the 1990 Act and advise the Secretary of State if asked about those matters.

2. The HFEA's 21 Members are appointed by UK Health Ministers in accordance with guidance from the Commissioner for Public Appointments. They determine all of the HFEA's policies and consider treatment, storage and research licence applications. Members are not appointed as representatives of different groups, but bring to the HFEA a broad range of experience and expertise. The Act requires that the Authority's Chairman, Deputy Chairman and at least half of the HFEA's Membership are neither doctors nor scientists involved in human embryo research or providing infertility treatment.

LICENSING OF CENTRES

3. Every clinic that offers IVF or DI treatment, the storage of gametes or embryos or which carries out human embryo research, irrespective of whether it is public or private, is required by law to be licensed by the HFEA. Not only does the licensing process ensure that proper standards are maintained, but it also assists in informing the HFEA about current and developing practices. As of 31 March 1999 there were 119 clinics licensed to carry out various activities.

4. Each clinic is inspected annually. The purpose of inspections is to assess the clinic's compliance with the 1990 Act, the HFEA's Code of Practice and its Directions. HFEA Licence Committees, each composed of at least three HFEA Members, take all licensing decisions. They determine the type of inspection required and if a licence should be granted, with or without conditions, suspended or revoked. Where there is the possibility that a criminal offence may have been committed contrary to the 1990 Act, a Licence Committee may decide to refer the matter to the Director of Public Prosecutions. The Authority has revoked three licences. In addition, several clinics have closed voluntarily having received initial notification of their failure to reach HFEA standards.

5. There are certain general conditions that apply to all licences. Additional conditions may also be added and, if so, are specific to the centre concerned. It is the duty of the individual named as the Person Responsible for each centre to ensure that the licence conditions for their centre are complied with. Licences have been granted subject to the condition that the Person Responsible be replaced because they have not discharged their duties as required.

DEALING WITH PATIENT COMPLAINTS

6. The HFEA has no statutory jurisdiction to deal with individual complaints against particular practitioners. However, the HFEA does have responsibility to ensure that proper practices are carried out in licensed centres in line with the requirements of the HFEA Act and its Code of Practice. This includes licensed centres having in place HFEA approved complaints procedures. The HFEA needs to be satisfied that the centre's procedures for dealing with complaints have been followed in any particular case. If there is doubt, the matter is referred to a Licence Committee who will decide whether any further action should be taken and whether there are any implications for the centre's licence.

CODE OF PRACTICE

7. The HFEA is required by the 1990 Act to produce a Code of Practice to guide clinics on how they should carry out licensed activities. The Code contains guidance on such subjects as: assessment of the welfare of the child; staff and facilities; assessment of donors; what information and counselling should be offered; legal requirements for consent; and the storage, handling and use of gametes and embryos. The Code is regularly reviewed and updated in the light of advances in techniques and to deal with issues that emerge from the licensing process. A breach of the Code of Practice must be referred to a Licence Committee.

8. The Code's second edition was published in June 1993, the third in December 1995 and the fourth in July 1998. Revisions of the Code must be approved by the Secretary of State and laid before Parliament. Work on the fifth edition has commenced.

APPENDIX 47

Letter from Lord Borrie QC to the Chairman of the Committee (PM 108)

I understand from Mr Asem Mohammed, who gave evidence to the Health Committee on 22 April, that you may be interested in my exchange of correspondence with Kim Howells MP on the subject of misleading advertisements for cosmetic surgery. I attach copies of the letters for you and am following the matter up with Baroness Hayman, as well as with the Advertising Standards Authority and the Director General of Fair Trading.

I look forward to reading your Committee's Report in due course.

30 April 1999

Annex 1

Copy of a letter from Lord Borrie QC to Mr Kim Howells MP, Parliamentary Under-Secretary of State for Competition and Consumer Affairs Department of Trade and Industry

MISLEADING ADVERTISEMENTS FOR COSMETIC SURGERY

I have recently met Mr A Mohammed of Hounslow, Middlesex, who showed me several adverse adjudications by the Advertising Standards Authority (ASA) in relation to advertisements of cosmetic clinics in the UK. As you know, the ASA is the principal self-regulatory body responsible for supervising the content

of non-broadcast advertisements (press, posters, cinema, and direct marketing) in the UK. The ASA is independent of both the government and the advertising industry.

Mr Mohammed is becoming increasingly concerned about the number and persistency of advertisements appearing, for example, in the back of women's magazines. They are factually inaccurate and seek to promote the benefits of aesthetic surgery without cautions or explanations of possible complications.

I understand from what Mr Mohammed showed me that a number of private clinics are flouting the ASA's rules by re-running advertisements in glossy magazines and brochures and on the Internet, after they have been condemned by the ASA. For example, in February 1998 the Cosmetic Surgery Centre, a London-based cosmetic surgery clinic, ran a brochure advertisement with a caption that read "...Our patients will have the best advice, will be treated by the best surgeons". In May 1998 the ASA asked for the advertisement to be withdrawn because it implied superiority. Between the period May 1998 and January 1999, the clinic continued to send misleading brochures to consumers using the same wording.

In July 1996 the Healthwise Medical Group, a North London based cosmetic surgery group, ran a brochure advertisement with the caption "Surgeons of the highest calibre". In September 1996 the ASA asked for the advertisement to be withdrawn. Between the period September 1996 and February 1999 the advertisers continued to send out similarly misleading brochures to consumers.

As a former Director General of Fair Trading, I am naturally concerned at the apparent lack of adequate controls over misleading advertisements in this area of commerce. Advertisements for cosmetic surgery have considerable appeal to vulnerable people and for that reason I feel that particular care needs to be taken by publishers and by the ASA to ensure misleading advertisements, once identified, do *not* reappear and are effectively banned.

I would be grateful if you would look into this matter. If you require any further information, I am happy that you or your officials should contact me personally.

26 March 1999

Annex 2

Copy of a letter from Kim Howells MP, Parliamentary Under-Secretary of State for Competition and Consumer Affairs, Department of Trade and Industry to Lord Borrie QC

Thank you for your letter of 26 March concerning your meeting with Mr Mohammed during which he outlined his concerns regarding the conduct of some private health clinics in the way in which they advertise their services, and questions the effectiveness of the Advertising Standards Authority in this sector.

I am sure you appreciate that the system of self-regulation which, in the first instance, governs advertising in the printed media in this country is generally very effective and provides an efficient means of sanctioning and guiding advertisers who do not comply with the industry's Code of Advertising and Sales Promotion. It probably results in faster action against offending advertisements than any legislation could on its own. However, that does not mean that we are unwilling to look into areas where the system may be failing in some way. My officials are acquainted with Mr Mohammed's concerns and have met him to discuss them. As a result of the evidence he has provided officials have also met with the ASA who will be providing details of the action they have taken in respect of the individual cases Mr Mohammed provided. No system of self-regulation can hope to provide absolute assurance against the types of claim Mr Mohammed has brought to our attention, particularly as several of them are published in brochures only available from the advertisers themselves. Nevertheless, over the last few years the ASA has concentrated extra effort on this sector and can point to a considerable degree of success whereby the great majority of advertisements of this type in magazines do now comply with the Code. No doubt there will remain some who continue to advertise in breach of the voluntary controls and in the face of adjudications by the ASA and my officials, in conjunction with the ASA, are considering how best this minority might be tackled.

As you will be aware, where the ASA's actions do not achieve the desired results the Authority can, of course, already refer misleading advertisements to the Director General of Fair Trading for investigation under the Control of Misleading Advertisements Regulations 1988. The Director General then has the power to seek an injunction against a particular advertisement. In addition, trading standards officers can investigate complaints about misleading statements in advertisements and, where appropriate, prosecute under the Trade Descriptions Act 1968.

However, it does appear likely that any solution to the problem will go much wider than advertising which is probably only the most visible manifestation of deeper problems concerning the way in which the private health industry operates generally. I have therefore passed earlier correspondence from Mr Mohammed to my colleague Baroness Hayman at the Department of Health to consider whether there are sufficient controls on the activities and conduct of private health clinics and practitioners, and whether, for example, there may be a case for specific advertising controls in this sector, such as those already covering the marketing of medicines, where additional controls have been found to be appropriate. You will also be aware that the Commons Health Select Committee is currently considering the broader question of regulation in the private health sector, in the course of which it is seeking the views of the ASA on advertising practice.

I hope this is helpful. A copy goes to the Advertising Standards Authority who may wish to comment on the specific examples Mr Mohammed has provided to you. I am also copying this letter to Baroness Hayman who may wish to comment further.

13 April 1999

APPENDIX 48

Memorandum by the Health Service Commissioner

PROPOSALS TO EXTEND THE POWERS OF THE HEALTH SERVICE COMMISSIONER (PM 109)

SUMMARY

1. This Memorandum discusses the proposition that my powers as Health Service Commissioner should be extended to allow me to investigate complaints related to independent healthcare. It briefly describes my existing powers; the relationship between my work and the NHS complaints procedure; and the difficulties I face in addressing complaints with an NHS and non-NHS component.

2. The Memorandum makes clear that extension of my powers would require primary legislation. It identifies the following potential advantages of the proposal:

- greater simplicity for complainants; and
- an opportunity to develop and apply common clinical standards for the consideration of complaints.

However, it points out that extension would lead to significant changes in the work of my Office.

3. The Memorandum concludes:

- that any extension of my powers should be drawn widely so as to allow me to investigate the full range of independent healthcare services, professions and settings;
- that new powers should be predicated upon the development of effective in-house complaints procedures in the independent sector; and
- that the cost of the significant extra resources I would need for this new work should not be met from the public purse.

INTRODUCTION AND CONTEXT

4. In the course of its enquiry into the regulation of the Independent Health Care sector the Select Committee has taken evidence from witnesses who have argued for the extension of my powers to allow me to investigate complaints related to non-NHS care. This Memorandum discusses the context of this proposal; potential advantages and disadvantages; and operational and resource implications.

5. The posts of Health Service Commissioner (HSC) for England, Scotland, and Wales were established on 1 October 1973 under the National Health Service Reorganisation Act 1973 and the National Health Service (Scotland) Act 1972. The legislation has been consolidated and amended, and is now mainly contained in the Health Service Commissioners Act 1993, as amended. Subject to certain statutory limitations, I can investigate any complaint against a body or person within my jurisdiction by, or on behalf of, a person that he or she has sustained hardship or injustice as a consequence of a failure of service, a failure to provide a service, or maladministration. I cannot investigate certain types of complaint, including:

- (a) personnel issues such as the appointment of staff, pay or discipline;
- (b) arrangements between NHS bodies, including family health service practitioners, if the complaint is made by the practitioner or an NHS body;
- (c) commercial or contractual matters (other than matters related to NHS contracts); and
- (d) matters where the complainant can seek a remedy through the courts, or has a right of appeal, reference or review before a tribunal, though I can waive this provision where I am satisfied that in the particular circumstances it would not be reasonable to expect the complainant to resort to such a remedy.

6. The law governing my powers does not extend to healthcare in the independent sector unless it is purchased by an NHS body.

THE NHS COMPLAINTS PROCEDURE

7. On 1 April 1996, a new national NHS complaints procedure was introduced, governed by Directions and informed by guidance issued by the National Health Service Executives. The procedure flowed from recommendations by the Wilson Committee in its report "Being Heard".

8. The NHS complaints procedure rests on improved processes for the local resolution of complaints as close to the point of service delivery as possible with, if this fails to satisfy the complainant, recourse to an independent review panel and, ultimately, to me. However, I am not governed in any way by the Directions and guidance which regulate the procedure, but by the separate legislation mentioned in paragraph 5 above.

9. The introduction of the complaints procedure has affected my work in a number of ways:

- (a) I cannot, by law, investigate a complaint until the NHS procedure has been “invoked and exhausted” unless, in the particular circumstance of the case, I consider it unreasonable to expect that to happen.
- (b) I investigate complaints about the handling of complaints within the NHS. In doing so, I apply the principles of fairness and natural justice, and the premise that failure to abide by the Directions and guidance can be considered as *prima facie* evidence of maladministration. I have, for example, investigated the actions of conveners and independent review panels if there is evidence of maladministration in the way they reached their decisions.
- (c) I can investigate complaints from NHS staff, or from family health service practitioners and their staff, if they believe that they have been treated unreasonably by the operation of the complaints procedure. I have investigated a handful of such complaints.

CLINICAL COMPLAINTS

10. I believe that increasingly the core business of my Office will be the investigation of complex clinical complaints. It is well equipped to do so through the developing expertise of my investigative staff, the employment of internal professional advisers, and the appointment of external professional assessors to consider the substance of complaints. In assessing the actions of clinicians I seek to establish whether the clinician concerned acted in a way consistent with the clinical judgment of a reasonable body of his or her peers, exercising a degree of professional skill that it was reasonable for the patient to expect. I do not look for “leading edge” clinical practice unless that is appropriate for the particular case. If I uphold a complaint I consider what would be appropriate redress. This may take the form of one or more of: an apology; assurances that remedial action will be taken; and, occasionally, financial redress. Other than financial compensation, these are remedies that are rarely available through the Courts. Similarly, the professional regulatory bodies are limited to action related to a clinician’s registration; and this will not be appropriate for the majority of complaints. If my powers were to be extended, the redress that I can recommend for complainants should, in my view, apply equally to the NHS and independent sectors.

11. Though I am able to investigate complaints about services purchased by the NHS from the independent and voluntary sectors, the restriction of my jurisdiction to services provided by the NHS presents some difficulty in the investigation of clinical complaints. The development of the “mixed economy of care”, and the juxtaposition of NHS and non-NHS care in NHS settings, restrict my ability, in some cases, to take a comprehensive view of an episode of treatment. This is likely to be especially common with complaints against, for example, dental practitioners, pharmacists, and optometrists, when NHS and non-NHS care are delivered side by side, and when NHS clinicians attend patients resident in, for example, private nursing homes.

12. These difficulties at the interface between the NHS and the independent sector, the full impact of which has, I suspect, yet to be felt, restrict my ability to consider and determine complaints in the round and are not easily understood by complainants. Taken with the perceived bureaucratic nature of the NHS complaints procedure, the complex jurisdictions of public sector Ombudsmen, the regulatory bodies and, of course, the availability of redress through the courts, complainants are likely to be confused and to believe that the objectives of providing simple, accessible and fair mechanisms for the resolution of complaints are not being met.

RELATED INITIATIVES

13. Many of these issues are currently being addressed. The Government has begun an evaluation of the NHS complaints procedure. I am working with the professional regulatory bodies and the NHS Executives to promote and improve public understanding of the jurisdictions and roles of key players in the complaints field. The Government has announced a review of the Public Sector Ombudsmen in England. I welcome these initiatives, and believe that the Committee’s review of the regulation of the independent healthcare sector is timely. I suggest that the Committee’s work should be seen in this wider context, and, also in the context of other aspects of the Government’s health agenda and legislative programme including:

- the establishment of the Commission for Health Improvement and the National Institute for Clinical Excellence;
- the development of a new NHS Charter;
- proposed new social care legislation including for the registration and inspection of private sector nursing and residential homes as set out in the White Paper “Modernising Social Services”.

THE POSSIBLE EXTENSION OF MY POWERS

The advantages of extension

14. I have mentioned the difficulty of investigating, in particular, clinical complaints which have an NHS and a non-NHS dimension. I have also mentioned the difficulties caused to complainants by the current complexities of complaints procedures and the gaps and overlaps in the jurisdictions of key players. Extending my role to encompass investigation of complaints about private healthcare would have the advantage of greater simplicity for complainants, especially those whose treatment straddles the NHS and independent sectors.

15. In addition, the appointment of a single Ombudsman with wide-ranging powers, would provide an opportunity to develop and apply common standards in dealing with complaints, particularly in the area of clinical judgment, and to make a contribution to the drive for clinical excellence.

The disadvantages of extension

16. Extension of my powers to include the independent sector would require a significant change in the way in which I operate. In particular:

- I would, in effect, become responsible for resolving disputes arising under commercial contracts, which would otherwise fall to the courts;
- many complainants would be likely to be looking for financial recompense: such recompense is seldom given under either the NHS complaints procedure or my own practice (though it could well be argued that both are too restrictive);
- at present, any recommendations which I may make for redress are not binding; there might be pressure to make them binding on the independent sector.

Scope of any extended jurisdiction

17. If it were decided to extend my jurisdiction to cover the independent health sector, legislation would be required. What should be the extent of any new powers if they are to achieve the objectives I have identified? The broad options are a wide-ranging jurisdiction similar to that of my current role, or a more narrow focus encompassing perhaps only clinical matters and leaving all other complaints to resolution through existing mechanisms and, if necessary, the Courts. I believe that a limited power would be very likely to perpetuate the current difficulties and would run counter to the desire of complainants not to resort to the law (and the inability of many to do so). Any extended power should encompass the delivery of private care in all settings, including within NHS facilities, family health service surgeries and premises, private hospitals and nursing homes.

18. It would clearly be impossible for my Office to deal with all unresolved complaints in the independent sector. It is therefore essential that the independent sector should have a satisfactory procedure to resolve complaints quickly and without the intervention of my Office.

19. So far in this Memorandum I have focused primarily on the medical profession. However, if the scope of my powers were extended to encompass the independent sector, I consider that all clinical professions should come within jurisdiction. That would enable me to examine complaints about private and mixed care delivered not only by doctors but also by dentists, pharmacists, optometrists, nurses and midwives and the professions supplementary to medicine.

Operational and resource implications

20. My Office would be unable to fulfil the wider role envisaged without a significant injection of new resources. I would clearly need more investigatory and professional staff; and there would be implications for common services, including accommodation. It would, in my view, be unacceptable for these increased costs to be met from the public purse. It is hard to estimate how large the additional requirement would be. Much would depend on the effectiveness of the complaints procedures mentioned in paragraph 18 above. In 1997 health expenditure in the private sector amounted to some £6.3 billion, compared with £42.7 billion in the public sector. However, it may well be that the private sector should be compared rather with the hospital sector of the NHS, which generates a larger number of complaints than other sectors in relation to expenditure: in 1997–98 formal complaints in England against the bodies in the Hospital and Community Health Service numbered nearly 89,000 compared with some 38,000 in the Family Health Services.

CONCLUSION

21. Extension of my jurisdiction to include the independent health sector would have advantages in terms of the developing mixed economy of care and to help simplify complaints procedures for complainants (and indeed healthcare staff). It would, however, significantly change the work of my Office. New primary

legislation would be needed. Any extension of my powers should be wide in scope, encompassing all the clinical professions and the delivery of private and mixed care in the full range of settings. It should, also in my view, be predicated on the development of an effective in-house complaints procedure in the independent sector. It would entail a substantial increase in the expenditure and staffing of my Office; this increase should not, in my view, fall on the taxpayer.

April 1999

APPENDIX 49

Memorandum by The British Orthopaedic Association (PM 110)

The British Orthopaedic Association is the professional association of orthopaedic surgeons. We have no disciplinary or regulatory functions but we are closely involved with training, education and professional standards in the field of trauma and orthopaedic surgery.

It is the view of the Officers of this Association that patients receiving medical treatment, whether under the NHS or in the private sector, should be under the care of a Registered Medical Practitioner on the Specialist Register. When surgical operations, that is to say procedures that involve the manipulation of structures beneath the skin, are involved the Medical Practitioner should be registered in an appropriate surgical specialty.

Only those on the Specialist Register are permitted to practise independently within the NHS and the same principle should apply in the private sector.

April 1999

APPENDIX 50

Memorandum by The Association of Anaesthetists of Great Britain and Ireland (PM 111)

1. BACKGROUND

1.1 The Association of Anaesthetists of Great Britain and Ireland represents approximately 7,000 anaesthetists. It has several categories of membership such as ordinary member, retired member, overseas member and trainees. The Association has a number of working groups of which one is the Independent Practice Committee which represents the interests of approximately 3,500 UK consultants plus about 200 Southern Ireland consultants.

1.2 The Association was founded in 1932 to promote the development and study of anaesthesia as a specialised branch of medicine. In 1935 the Association established the first qualification in the world of Anaesthesia, the "Diploma in Anaesthetics". In 1939 the Association advised the UK government on the provision of anaesthesia for civilian and military services which resulted in the training of a large number of physicians anaesthetists, many of whom were absorbed into the National Health Service in 1948. The Association launched a quarterly journal, *Anaesthesia*, in 1946 which is now published monthly and is an internationally renowned scientific publication.

2. RELATIONSHIP WITH THE ROYAL COLLEGE OF ANAESTHETISTS

Largely as a result of the efforts on the part of the Association to develop anaesthesia as a specialty in its own right the Royal College of Surgeons established a Faculty of Anaesthetists in 1948. This arrangement served the profession well and many anaesthetists were proud to carry the qualifications FFARCS (Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons). However, as anaesthesia grew both in stature and complexity it became clear that it would be necessary to establish a College in its own right and following discussions with the Royal College of Surgeons, the College of Anaesthetists was established within the same building as its surgical brothers in Lincoln Inns Fields in 1988. The Royal Charter was granted to the College of Anaesthetists in 1992. The College, however, is inhibited by the terms of its Charter from entering into negotiations on terms and conditions of service etc and devotes itself almost entirely to the area of standards of training and practice. The relationship between the College and the Association is cordial as demonstrated by the joint publication in 1998 of the Good Practice Guide for Departments of Anaesthesia.

3. PRESENT POSITION OF ANAESTHETISTS IN THE INDEPENDENT SECTOR

3.1 By far the majority of surgical interventions are carried out in the United Kingdom under general anaesthesia and, therefore, require the attendance of an anaesthetist. Standards for training and practice in anaesthesia are laid down by the Royal College of Anaesthetists and it is the view of the Association of Anaesthetists of Great Britain and Ireland that exactly the same standards and regulations should apply to the private sector as are appropriate within the NHS. It is, therefore, also our view that the provisions and standards set by the National Institute for Clinical Excellence (NICE) and the Commission for Health

Improvement (CHIMP) should apply. We would, therefore, hope that the provisions as outlined in "A First Class Service" (HSC1998/113) should be applied.

3.2 The question of clinical governance is a difficult one. It is the view of the Association that, wherever possible, the position occupied within the NHS by the Medical Director should be represented within the Independent Sector Hospitals by the Chairman of the Medical Advisory Committee.

4. RECOMMENDATIONS

4.1 It is the strongly held view of the Association of Anaesthetists that all anaesthesia delivered within the Independent Sector should be provided by only those who hold or have held an NHS consultant appointment or its equivalent, that these holders will be on the specialist register and that the same standards for granting anaesthetists rights to practice in private hospitals be applied as would be applied to the appointment to a consultant post within the NHS.

4.2 It is further the view of the Association that the same standards of monitoring during the anaesthetic episode, and assistance for the anaesthetist throughout the pre, per and postoperative period should apply within the Independent Sector as are laid out and expected during the peri-operative period within the National Health Service. Standards for both assistance for the anaesthetist and monitoring during anaesthesia have been set both by the Royal College of Anaesthetists and the Association of Anaesthetists in various publications by those bodies.

5. CONCLUSION

It is entirely the view of the Association of Anaesthetists that safety for the patient is paramount and the decision by the patient to pursue surgery within the Independent Healthcare Sector should in no way reduce the standard of care or add any measurable risk of an untoward outcome from their surgical and anaesthetic experience.

APPENDIX 51

Letter from the Chairman of the Board of Trustees London Consultants' Association to the Clerk of the Committee (PM 114)

It was a great pleasure to meet you and Members of the Health Select Committee when you visited the Wellington Hospital. As you know, I met you there with the Hospital Chief Executive, the Group Chief Executive and Chairman and the hospital management staff in my capacity as Chairman of the Medical Advisory Committee. I do hope you were impressed with the quality and standards exhibited in the hospital. I believe that we are justifiably proud of the care we extend to our patients.

I know there are many issues that the Health Select Committee is having to face and your remit is extremely wide. However, in our conversation during the visit we touched on certain topics and I am, therefore writing, at your suggestion, to bring up these points. I do so in my other capacity as Chairman of the London Consultant's Association, an organisation that has support from five hundred consultants in London.

We were discussing the question of quality assurance and who should be controlling this in the private sector. Obviously there are some areas of concern, for example, small-unsupervised establishments carrying out certain procedures without any form of regulation. However, on the broader front and in established private hospitals, quality assurance programmes should be carried out in a structured and proper way by the consultant, nursing and managerial staff adhering to national and local guidelines and governance. We have no problem with this and in fact would welcome it. We already do this and will increase our efforts in the major private hospitals. The private sector should do everything that is done in the NHS in terms of governance.

The London Consultant's Association is a group that has been set up in order to maintain freedom of choice and clinical standards and to try and counteract the intrusions that insurance companies are making into clinical matters. We do not believe that it is right that some major insurers should use their own so-called quality assurance standards when their motives are primarily financially driven.

During our discussions, Mrs. Wise mentioned some unfortunate but not uncommon, examples of Managed Care that she had seen in the United States. In the United States the advance of Managed Care and the Preferred Provider systems has resulted in some serious clinical problems. This has now led to a backlash from patients and the profession. New Federal laws have been enacted to control some of the draconian rules imposed by the insurance companies, for example the one which prevented women staying in hospital for more than 24 hours after childbirth. Another example is the law to stop insurance companies from imposing "gagging" clauses upon doctors that prevented them from telling the patient that alternative and possibly better treatment existed than that on offer through their own insurance company. The fact that a mastectomy for breast cancer can be done on a day care basis does not mean that it should be done this way.

In the United States the introduction of Managed Care some years ago did result in a lowering of costs. However, the whole system of healthcare in America is totally different to the UK. There are far more

specialists per head of population, very few General Practitioners (who act as the gatekeeper for the patients specialist care in the UK), very different patient expectations, high litigation and defensive medicine and almost certainly some unnecessary operations and treatments. This medical culture, when placed against a backdrop of much higher administrative costs in the hospitals (quoted as 22 per cent) and evidence of fraudulent claims from many hospitals (and doctors), meant that savings could be made. Now the costs are rising again and Managed Care has lost its impact.

Some of the private medical insurance companies in the UK are copying this American model of Managed Care and are starting to impose clinical and other restrictions. They are doing this despite the fact that the situation here in the UK is in no way comparable to the USA. There is much more efficiency on the part of the hospitals and the medical culture is quite different with statistics showing fewer procedures per head of population in the UK when compared with the USA.

We did discuss some examples of how the insurance companies intrude into patient care. Insurers are trying to assume the gatekeeper role and replace the GP who is the natural and proper guardian of the patient's referral. As an example, I told you of a case where the insurers offered financial incentives to a 75 year old patient (15 per cent off the following years subscription) to have his hernia operation in a cheap day-centre without any knowledge of the patients background medical condition. This was done despite a direct letter of referral to the consultant by the General Practitioner.

There are also concerns that insurers are setting up networks of consultants who are paid a financial incentive each year if they stick to certain protocols, such as length of hospital stay for their patients. We believe that such schemes (ie the BUPA Partnership Scheme) are unethical as it induces the doctor to act for extra financial gain when it might not be in the patient's best interests.

Partnership schemes between the consultant and the insurance company are contracts and change the normal doctor/patient relationship. Implicit in these schemes is the suggestion that "business" will be directed to the partnership consultant. This reduces the status of the patient to nothing more than a commodity and interferes with the normal pattern of referral based on the patient's GP.

As a result of this trend towards consultant Preferred Providers we are starting to see the emergence of another phenomenon namely separate groups who set up as Brokers to attract the privately insured, whether individuals or those in company schemes. These groups are trying to "employ" consultants at low rates of remuneration and promise to send them "business". They act as middlemen in this process and earn a commission. The obvious danger is that the types of doctor who might sign up to work in these schemes are unlikely to be the top surgeons and physicians and again patients are going to be treated as commodities.

Although the Office of Fair Trading has been informed about the insurers Hospital Preferred Provider schemes, this is also an issue that could impact on standards. Our Consultant Association does not wish to involve itself with specific examples of hospital recognition by insurers but we are against this in principle as there are obvious conflicts of interest. The question here is whether the major insurance companies should be both a purchaser and provider of health care. We are concerned also that the insurance companies are beginning to use dubious "quality assurance data" not only to recognise hospitals but also consultants. This can be manipulated to their financial advantage. More importantly it impacts on consultant practice and ultimately on patient care.

We believe that the regulation and recognition of private hospitals and consultants should be a matter for independent outside evaluations and regulators and not based on those with insurance muscle and vested interests.

I would like to stress that some insurers behave in a responsible manner and continue to support the traditional methods of patient referral and clinical controls. These insurers are entitled to expect, along with the patients whom they insure, that clinical governance will increase and that other independent forms of regulation of hospitals and consultants will occur. These systems are largely in place in main stream private hospitals. The insurers are also entitled to expect cost effectiveness. The medical profession accepts that we must be cost effective whether working in the NHS or in the private sector.

We believe that imposing Managed Care and Preferred Providers systems, whether for consultant or hospital, will eventually end up in the situation that pertains in the United States in which clinical standards and care have suffered. It has not worked there and it will not work here. I would be happy to enlarge on any of these points but I would hope that some firm statement or action by your Committee and possibly also the Office of Fair Trading would halt this unfortunate and accelerating tendency.

APPENDIX 52

Letter from Head of UK Public Policy BUPA to the Clerk of the Committee (PM 61A)**INQUIRY INTO THE REGULATION OF INDEPENDENT HEALTHCARE**

BUPA Hospitals do not have any Medical Advisory Committee (MAC) Chairmen who are not medically qualified. I understand that the Hospital Specialists and Consultants Association have been asked to substantiate their claim about “non-medically qualified MAC chairmen” but have been unable to do so.

All BUPA Hospitals Resident Medical Officers (RMOs) have full registration on the Principal List of the General Medical Council and must also maintain current Resuscitation Council UK certification in Advanced Life Support and Advanced Paediatric Life support. This certification must be obtained before RMOs in our hospitals take up their posts.

It is BUPA Hospitals policy that patients must have a referral letter from their General Practitioner, or another Consultant in the case of a tertiary referral. The only exceptions to this rule are physiotherapy patients and patients receiving a BUPA Health Screen.

I am advised by the Deputy Managing Director of BUPA Hospitals that he can presently detect no significant variations in the patterns of interventions of insured and self pay patients in our own hospitals. It must be observed however that BUPA Membership and other leading specialist PMI groups have made considerable investments in recent years to develop products that seek to secure best value and best practice for their members. It would not be surprising if there are variations at the margin between the demand for services from self pay patients (under advice from their General Practitioners) and the demand for services from patients whose PMI products also have rigorous provider quality assurance and best value mechanisms built into them.

BUPA Hospitals are however also constantly improving their methods of monitoring patterns of clinical intervention and outcomes, locally and nationally. It is always BUPA’s intention to ensure that emerging best practice is disseminated as quickly and widely as possible, to ensure best practice and best value; in the first instance to our own patients, but beyond that through teaching, lecturing, medical and other health care publications also to all patients nationally and world-wide. Overall BUPA Hospitals spent £1.2 million on staff education and training in 1998 and the BUPA Foundation awarded almost £1.1 million in research grants, mostly for clinically related topics.

BUPA think that this Inquiry has already proved to be a very valuable exercise in building understanding between all the parties involved; and look forward to giving very careful consideration to the Inquiry’s report in due course.

19 May 1999

APPENDIX 53

Letter from the Chief Executive Nuffield Hospitals to the Clerk of the Committee (PM 36A)

Further to my appearance before the Select Committee on 25 March to present oral evidence, I have pleasure in submitting as an annex to this letter certain supplementary written evidence. I hope this additional information will be of assistance to you, the Chairman and the Committee members during the final stages of the inquiry.

The subjects covered in the appendix are:

- Nuffield Hospitals’ comments on the evidence submitted by the Royal College of Paediatrics and Child Health;
In this we describe the existing policies and procedures and highlight the fact that independent scrutiny of children’s services occurs via the Health Quality Service audit;
- Details of the methods by which Nuffield Hospitals brings its complaints procedure to the attention of patients;
This seeks to respond to Dr Brand’s request for further information;
- Nuffield Hospitals’ policy on the qualifications and training of resident medical officers;
In this we confirm our RMO policy which is that they should have both Advanced Life Support and Paediatric ALS certification;
- Nuffield Hospitals policy on the status of the chairmen of hospital Medical Advisory Committees;
We confirm that all Nuffield Hospitals’ MAC chairmen are medically qualified;
- Nuffield Hospitals’ policy on referrals to consultants by general practitioners;
We provide evidence that we actively encourage patients to be referred by their GP;

- Details of training and development initiatives for clinical staff within Nuffield Hospitals; Amongst other things we confirm that Nuffield Hospitals is actively involved in the pre-registration training of nurses;
- Nuffield Hospitals' comments on the case of the late Mrs Christine Maloney in response to the points made in evidence by her husband, Mr Graham Maloney; We provide Nuffield Hospitals' perspective on the above case.

18 May 1999

Annex

Supplementary memorandum

1. COMMENTS ON THE EVIDENCE SUBMITTED BY THE ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH

We recognise that the concerns expressed by the Royal College of Paediatrics and Child Health ("the College") were generalised in nature and levelled as much at NHS hospitals as independent hospitals. We wish to emphasise that we endorse the general objects expressed by the College in seeking, amongst other things, to raise the standard of care for this vulnerable group of patients.

Nuffield Hospitals has supported such objectives for several years and as long ago as 1994 the charity co-sponsored the production of a report published by Action for Sick Children (formerly NAWCH) "*Setting Standards for Children Undergoing Surgery*" (ISBN 0 904076 15 6). The report established standards for hospitals in both the state and independent sectors in respect of the services that should be provided for children and their families when children undergo surgery. The then Chief Nurse of Nuffield Hospitals was a member of the Advisory Group that produced the report.

Since 1994, these standards have acted as the cornerstone of Nuffield Hospitals' policies and procedures on the care of children in hospital. An example, for illustrative purposes, of the policy in use in one of our hospitals (in this case the East Midlands Nuffield Hospital in Derby) is included at Annex 1. It will be seen from the introduction to the policy (page 8) that:

"... the standards stated in the Welfare of Children and Young People in Hospital, are fundamental to our philosophy and practice."

This document also includes at page 6 a copy of the overarching corporate policy.

Compliance with these policies and procedures is audited via the independent Health Quality Service (formerly Kings Fund) organisational audit process. A copy of the organisational standard laid down by the Health Quality Service ("HQS") in respect of children's services is shown at Annex 2. Please note that the very first audit criterion of this standard ("*Standard 28 Children's Services*") requires that:

"The Welfare of Children and Young People in Hospital (Department of Health, 1991) and Child Health in the Community (Department of Health, 1996) the Children's Charter and Health Services for Children and Young People (Action for Sick Children) are used to inform the way in which care is organised and delivered."

The Committee may also wish to see the executive summary of the report of the HQS audit carried out some 18 months ago at the East Midlands Nuffield Hospital. The summary is shown at Annex 3. This is of particular relevance because the medical member of the HQS audit team was a consultant in child health and the hospital's paediatric services were specifically commended by the audit team. This is consistent with the written evidence submitted to the Committee by the Royal College of Nursing who acknowledged that:

"...there are certainly some areas of very good practice in the care of children in the independent sector, and some of the major groups have corporate policies on children's issues."

The Committee may also wish to be aware of the Nuffield Hospitals "Best Practice Initiative" which has provided an effective vehicle for the dissemination of current good practice across the group. A leaflet describing the Best Practice Initiative is enclosed at Annex 4.

However, we are not complacent and recognise the ever-present risk of standards deteriorating or failing to keep pace with modern developments—a risk that is especially high when there are changes in key hospital personnel. Compliance checks like the HQS audit are therefore an important management tool and we are intent on ensuring that all of our hospitals attain the exemplar standards of the East Midlands Nuffield Hospital.

To this end, all Nuffield Hospitals (other than the five new acquisitions) are undergoing a rolling programme of HQS audits. Of the 35 longer established hospitals, 20 have already gained full accreditation and six partial accreditation. The remaining hospitals will be undergoing HQS audit over the coming months.

In summary, we believe we can demonstrate objectively that high standards are achieved in our hospitals, that these standards are codified and are audited independently against nationally recognised minimum criteria, and that there is a commitment to and a process for disseminating good practice across the whole organisation.

2. DETAILS OF THE METHODS BY WHICH NUFFIELD HOSPITALS BRINGS ITS COMPLAINTS PROCEDURE TO THE NOTICE OF PATIENTS

During the hearing on 28 March, the Chief Executive of Nuffield Hospitals was asked by Dr Peter Brand MP to provide details of Nuffield Hospitals' complaints procedure. A copy of Nuffield Hospitals' complaints policy is shown at Annex 5.

The procedure for making a complaint is brought to patients' attention in a variety of ways. For example, the patient information section on Nuffield Hospitals' recently established web-site includes a page on "Patient Feedback"—a copy of this page is enclosed at Annex 6. All patient bedrooms in Nuffield Hospitals have on the bedside table an information folder within which reference is made to the complaints procedure. The text reads as follows:

"If you have a complaint";

If you are not satisfied with any aspect of the care you receive, please ask to speak to Matron, [Matron's name]. If your concerns are not resolved, please contact me [Hospital Manager's name] directly.

If, when you have expressed any concern to me, you are still dissatisfied, you may write to the Chief Executive, Nuffield Hospitals, Nuffield House, 1-4 The Crescent, Surbiton, Surrey KT6 4BN.

Our policy is to deal with complaints fully and promptly, and to use your comments to maintain and improve our services. This helps us to ensure you always receive the best possible care."

Many hospitals provide details of the complaints procedure in the form of notices on the walls of their outpatient departments and the text used for these notices is very similar to that above. As part of the pre-admission process, there is a standard format of literature and reference to the complaints procedure is clearly made in this documentation. An example is shown at Annex 7.

We recognise that at present our procedure does not include an independent review stage. As we said in our written evidence to the Committee, we would be keen to see a sector-wide independent review process to which all parties—hospitals, doctors and insurers—have signed up.

3. QUALIFICATIONS OF RESIDENT MEDICAL OFFICERS

On several occasions during the course of the Committee's inquiry, the issue of the qualifications and competence of Resident Medical Officers (RMO's) has arisen.

Nuffield Hospitals' current policy is that all RMO's (including locums) must possess current certificates in Advanced Life Support (ALS) and Paediatric Advanced Life Support. Doctors appointed as RMO's are at either SHO or Registrar level.

The majority of RMO's working in Nuffield Hospitals are doctors from overseas who wish to broaden their clinical experience by working for a period of time in the UK. They are very carefully selected against a previously agreed specification by an international recruitment and selection agency, O'Grady Peyton (UK) Ltd. The agency processes on our behalf, GMC registration, work permits, MDU cover and provides each hospital with the doctor's details including cv's, references, immunisation status and ALS and PALS certificates.

Members of the Committee may wish to be aware that in 1998, Nuffield Hospitals undertook a thorough review of its cardio-pulmonary resuscitation policy. The review was carried out by a multidisciplinary team that included Nuffield Hospital's corporate adviser in anaesthetic services. The adviser is also Clinical Director in the Department of Anaesthesia of a large provincial teaching hospital and he is one of a panel of 11 consultant-level medical advisers who provide advisory input alongside that of hospital-based Medical Advisory Committees.

4. CHAIRMEN OF MEDICAL ADVISORY COMMITTEES IN NUFFIELD HOSPITALS

In its written evidence to the Committee, the Hospital Consultants and Specialists' Association ("the HCSA") asserted that MAC chairmen are sometimes not medically qualified.

We would like to take this opportunity to assure the Committee that all MAC chairmen within Nuffield Hospitals are medically qualified. Further, we know of no instance, neither within Nuffield Hospitals nor elsewhere, of a MAC chairman being other than a medical consultant. Were it to happen, we believe it would be highly unusual and could only occur with the consent and support of the wider consultant body within the local medical community. The reason for this is that it is the norm for MAC chairmen to be elected by ballot from within their peer group.

The Committee may wish to seek clarification from the HCSA as to the basis of their assertion.

5. REFERRALS TO CONSULTANTS BY GENERAL PRACTITIONERS

During the hearing on 25 March, a member of the Committee expressed concern that it is no longer the norm for private patients to be referred to consultants via a general practitioner. The witnesses expressed surprise at this assertion since it ran counter to their knowledge of prevailing practices and protocols within their own organisations.

The policy within Nuffield Hospitals is to actively encourage patients to be referred privately via their GP. To illustrate this, a page from our web-site is reproduced at Annex 8.

We would also draw the Committee's attention to the guidance issued to doctors by the General Medical Council in paragraph 35 of their publication "*Good medical practice*":

"Specialists should not usually accept a patient without a referral from a general practitioner. If they do, they must inform the patient's general practitioner before providing treatment, unless the patient tells them not to or has no general practitioner. In these cases the specialist must be responsible for providing or arranging any aftercare which is necessary until another doctor agrees to take over."

While the GMC guidance does not explicitly prohibit consultants from accepting self-referred patients, we believe it acts as a robust statement of good practice to which the great majority of consultants adhere.

6. RECRUITMENT TRAINING AND PROFESSIONAL DEVELOPMENT OF NURSING STAFF

During the hearing on 25 March, a Committee member raised the issue of the alleged "poaching" of nurses by the independent sector from the NHS.

We would like to comment further on this matter and begin by raising the fundamental question of whether the NHS can assert a right to a career-long tenure of service from nurses who have been trained "by the State". Does the NHS have such a right? We believe not. By way of analogy, we note that men and women trained in a wide range of skills and professions in the Armed Services are not required to work in the public sector on leaving the Army, Navy or Air Force. We see no case for treating nurses any differently.

Nonetheless, we wish to make the Committee aware that Nuffield Hospitals is in fact actively involved in the pre-registration training of nurses; 24 of our 40 hospitals provide clinical placements for pre-registration nurses. Four other hospitals are currently in discussion with nearby universities to arrange clinical placements and others will follow.

Student nurses may either be undertaking the *Common Foundation Programme* (ie during the first 18 months of training) or the *Adult Branch Programme* (ie the second 18 months of training). The universities stipulate that Nuffield nursing staff who mentor students must possess the *ENB qualification ENB 998 Teaching and Assessing in Clinical Practice* and rigorously audit the quality of the learning environment.

Over the last three years, some 575 such placements have been provided. The list of participating hospitals is to be extended later this year. We are convinced that all parties benefit from this relationship.

Nuffield Hospitals is also heavily committed to the post-registration professional development of its nursing workforce. We run an Education and Practice Development Centre based at our hospital in Wolverhampton (but serving the whole of the UK). Last year over 4,000 days of training were provided both at the Centre and at hospitals. The courses are accredited by the English National Board and the University of Central England. Of the 260 students who attended courses held at the Centre in 1998, 40 (15 per cent) were from the NHS.

A summary of the Centre's 1999 Education Programme is shown at Annex 9.

We would also like to emphasise that the independent sector does not recruit nurses exclusively from NHS hospitals. Other sources of supply include:

- other independent hospitals;
- the medical branches of the Armed Services;
- the medical departments of commercial organisations;
- overseas hospitals;
- nurses completing *Return to Practice* courses following a career break.

In 1998, of the 287 nurses recruited by Nuffield Hospitals, almost half came from sources other than the NHS. Moreover, it is not a "one way street". In the same year, 85 nurses left Nuffield Hospitals to join the NHS. We believe this is healthy and provides valuable cross-fertilisation of ideas and influences between the two sectors.

We should mention finally that between 1993 and August 1998, Nuffield Hospitals ran its own ENB accredited EN/RGN conversion course. As part of this initiative, we made a substantial commitment, in terms of both money and time, to providing some 300 enrolled nurses with the necessary additional training to become registered general nurses. This had the effect of retaining within healthcare a very valuable and skilled resource.

7. COMMENTS ON THE CASE OF THE LATE MRS CHRISTINE MALONEY

Members of the Committee will recall that Graham Maloney, the husband of the late Mrs Christine Maloney, presented written evidence and was one of several witnesses who gave oral evidence to the Committee on 4 March. We would be grateful if the Committee would consider Nuffield Hospitals' perspective on the case—a case which concerns events occurring some five and half years ago.

Mrs Maloney died at the age of 46 in the Cleveland Nuffield Hospital in November 1993. We would like the Committee to be aware that Nuffield Hospitals has always acknowledged that there were shortcomings in the care and support offered to Graham Maloney during his wife's final hours at the hospital. We believe that the precipitating factor in this matter was an unfortunate breakdown in the relationship between the ward sister on duty on the night of Mrs Maloney's death, and Mr Maloney.

We wish the Committee to be aware that these difficulties were acknowledged by the Matron of the hospital, and indeed the sister herself, at a very early stage. In a letter to Mr Maloney of 14 January 1994 in response to Mr Maloney's original complaint, the Matron wrote:

"The sister is very aware that she, as the person in charge, failed to give you the support you required that night. She regrets very much that she was unable to communicate with you that night and reacted badly to what she felt was criticism of her professional ability and judgement. Death is always extremely difficult to cope with, even by the most experienced nursing staff, and Christine's especially because of many factors and the strong relationship she had built up with the nurses during her illness."

It is relevant at this point to highlight the fact that during her final illness Mrs Maloney was an inpatient at the Cleveland Nuffield Hospital for an unbroken period of 33 days between 18 October and 23 November 1993. During this period, the nursing staff built up a close relationship with Mrs Maloney and believed they had gained a good understanding of her wishes and preferences.

Indeed, in the original letter of complaint dated 21 December 1993, solicitors acting for Mr Maloney wrote:

"It appears from Mr Maloney's instructions that up until that final night the standard of care given to Mrs Maloney could not in any way be criticised but on the night of her death it would appear that the hospital's usually high standard of care fell to such a level as to cause Mr Maloney some distress and dissatisfaction."

We believe the Committee should also be aware that in addition to her final stay in the hospital, Mrs Maloney attended the Cleveland Nuffield Hospital for treatment on over 20 separate occasions between 1991 and her death in 1993. We contend that Mrs Maloney herself had ample opportunity to form her own views of the capabilities of the nursing staff at the Cleveland Nuffield Hospital. The fact that she chose to spend her final illness there suggests that she was nothing but satisfied with the normal standard of care.

In terms of the availability of nurses on the night of Mrs Maloney's death, independent investigations carried out by Tees Health Authority ("the HA") during two separate inquiries (November 1995 and June 1997) found that staffing levels were satisfactory.

We believe that the fundamental lesson to learn from Mr Maloney's experiences is the need for a transparent, sector-wide independent review and arbitration process to investigate patients' and relatives' complaints when they have not been resolved to the complainant's satisfaction.

There is considerable common ground between Mr Maloney and Nuffield Hospitals on the need for better statutory complaints procedures within the independent healthcare sector. These are points that we made to the Committee in our written evidence.

May 1999

APPENDIX 54

Supplementary memorandum by Capsticks Solicitors (PM 75A)

The purpose of our submission was to talk briefly about our empirical knowledge of current strengths and weaknesses in the regulatory system for private hospitals, from the perspective of Health Authority inspection, and to analyse some main factors in the current situation. This was followed by some concrete practical examples, from two specific districts, of recent problems.

The experience derived from working with numerous Health Authorities over several years was that there is very little significant enforcement action, and that issues of concern are very rarely brought to the attention of Health Authority lawyers. Instead, concerns are addressed in inspection reports, and sometimes in warning letters, with which the persons running the private hospitals comply. More generally, it is felt, certainly in some quarters, that there has been a great improvement in practices, facilities and training over the past few years, no doubt partly because of market pressures.

Even so, there may be a choice here, when considering the reason for this, between there actually being uniformly high standards throughout the country and there being weak links in the current enforcement process.

There are, in our view, three main elements to the current situation:

1. Accreditation.
2. Professional accountability.
3. Composition of inspection units.

ACCREDITATION

There are 4 main accreditation schemes in this field, of which the most wide-ranging, prescriptive of standards, and well-regarded is the King's Fund's own scheme. Another is the ISO 9002, a model for management processes. Additionally, there are schemes run by the National Association of Theatre Nurses and the Royal College of Pathologists, amongst others.

It is considered that these accreditation schemes have a useful contribution to make, but that they are not the complete answer, and that there is still a role for Health Authority inspection in advising and helping to promote good standards. Concerns have been expressed as to the actual implementation of the accreditation requirements and programmes and as to the frequency of the accreditors' monitoring and inspection of the premises.

ACCOUNTABILITY

The main sanctions, at present, are those of the GMC and UKCC, together with pressures from the medical and commercial insurers. The creation of the National Institute of Clinical Excellence (NICE) and the Commission for Health Improvement (CHIMP) is likely to make the medical model of accountability, in conjunction with the principles of clinical governance and clinical audit, more formalised and pro-active, at least within the health service: whether to use these as the relevant model for the private sector also must be a topic for discussion and debate.

INSPECTION TEAMS

The situation as regards inspectors' professional backgrounds and experience is a lottery. In some areas, for example, there is a serious shortage of people with up-to-date theatre nursing experience, and those who do possess this can find themselves providing services to several different Health Authorities. In some areas, also, apart from the Director of Public Health there is no ready access to specialist medical expertise, nor is there a medical member of the inspection team.

This must be in part the result of the weighting of inspection case loads, given that private hospitals are still very much outnumbered by nursing homes, caring for elderly patients. However, this can result in a loss of credibility and in the imposition, in Health Authority guidelines, of wrong standards, those applicable to the care of the elderly and not to the private hospitals.

On the basis that the goal is the achievement of reliability and thoroughness of auditing by Health Authorities, it is fortuitous whether or not this goal is indeed achieved, rather than this being guaranteed by or integral to the current regulatory system.

We then presented some specific examples of the current system in practice:

District One

The Inspecting Officer in this district was theatre-trained and had experience of running a small hospital. She started regulating and inspecting private hospitals in the district some ten years ago at which point there were eight hospitals and a situation she described as "horrific". One hospital had theatres which were unfit for use: in response to the threat of regulatory action it closed the theatres and upgraded them. Had this not occurred the Health Authority would have taken steps to cancel its registration, with the effect of forcing its closure. Only six or seven years ago there was still a major problem with the private hospitals in the area. For example, hospitals would only have generators for the theatres and not in other areas; training was poor; and there was no proper vetting of staff. There was also an absence of resident medical officers and a lack of proper on-call medical cover. It would also be common for there to be no call bells in patient areas.

The Inspector acknowledged that there has been a transformation in standards in the last five years. Three of the older, smaller private hospitals have gone, and five remain. Regulation and pressures from the market have both led to improvements. The Inspection Unit pushed private hospitals in the direction of accreditation and this has had a positive influence in raising standards. The problem nonetheless is that all the various accreditation schemes have different standards: there remains a need for an overall regulatory body to bring everything together.

In this district the Registration and Inspection Unit does have an active role in promoting good practice, which is acknowledged and accepted by the private hospitals. As an example, the hospitals in the area were very keen to receive information from the Health Authority on how it produced its acute-sector inspection format and the accompanying clinical audit tool. The Unit also has an important role in dealing with

applications for registration in respect of proposed new-build hospitals. It is the experience of the Inspecting Officer dealing with the sector that a lot of work is involved in ensuring that adequate services and facilities are provided. Many issues are not addressed and there is a tendency for providers only to look at rooms/beds, not the supporting facilities. Very often the adequacy of clinical areas, treatment rooms, ward areas, sluicing facilities and bathing facilities (particularly assisted bathing) is not properly addressed.

It is acknowledged by the Inspecting Officer that there has been a historic problem with Health Authority Inspection Units regulating private hospitals given that district nurses have lacked credibility. There is a need for Inspectors to have a background in the acute sector, particularly in theatre nursing. As much as anything this is to counter excessive and inappropriate regulation such as the requirement for there to be recreational facilities and large communal areas in the hospitals. However, that should not detract from the evidence of the results of effective regulation and inspection produced by the involvement of theatre-trained Inspection Officers. What is clear, however, is that there is a need for access to up-to-date clinical specialists, to ensure regulation is effective.

External regulation and self-regulation/accreditation are not mutually exclusive but complementary. Accreditation should lead to regular monitoring as well as to providing the hospitals with the documentation required. In contrast health authorities only generally inspect twice-yearly and it is beyond their resources and current role to provide documentation for internal use in private hospitals.

District Two

From our audit of inspection reports in respect of eight hospitals in this district since open reporting was introduced in April 1998, a wide range of deficiencies was revealed, notwithstanding that these hospitals have accreditation, which calls into question the effectiveness of monitoring compliance with those schemes. As with District One, the Inspecting Officer in this district is also theatre-trained.

The principal deficiencies covered the areas of health and safety and staffing, namely:

HEALTH AND SAFETY

- Resuscitation trolleys;
- Fire safety;
- Radiator covers;
- Hot water temperature controls;
- Call bells;
- Testing and maintenance of emergency lighting equipment.

STAFFING

- Theatre lists;
- Timing and length—one doctor was on duty from 7.00 a.m until midnight and then was on-call the next day;
- Lack of specialist nursing especially by Registered Sick Children's Nurses;
- Poor recruitment practices;
- Record keeping;
- Complaint handling.

From an analysis of inspections in this district, there is clearly a role for external regulation as well as for accreditation. Indeed, effective accreditation systems will influence the degree of regulation and inspection required in practice for a particular hospital. It is our opinion that regulation of an external nature needs to follow a clinical governance model but at the same time to build on current good practice with regard to standard-setting in terms of facilities and services in private hospitals, and that regulation is most effectively carried out by inspectors with the appropriate professional background.

11 May 1999

APPENDIX 55

Letter from the Chief Executive General Healthcare Group to the Clerk of the Committee (PM 51A)

When I gave evidence on 25 March there was a small number of areas where further information was required, and I am now writing to provide that information. In order to cross refer to the context I will refer to the relevant paragraph of the Transcript of the hearing held on 25 March. The outstanding issues are:

Qualifications and Experience of Resident Medical Officers

Our Resident Medical Officers (RMOs) are fully qualified doctors employed or retained by us. There is at least one present and on duty at all times in each of our Hospitals. Where, however, a Hospital runs a cardiac or other specialist surgical programme then we will normally provide additional medical cover with experience in that specialty.

All our RMOs are fully qualified, with both an MBBS or equivalent, and at least two years senior house officer or registrar experience. They must also have a certificate in Advanced Life Support from the Resuscitation Council. Where paediatric programmes are present, there is a requirement that the certificate be in Paediatric Advanced Life Support.

Children in Hospitals—(QQ 355, 358)

We take very seriously the provision of a safe, secure and welcoming environment for children. Therefore it is our policy to have available and present for the care of any child a Registered Sick Children's Nurse. However, the unique needs of children go far beyond this. I thought that it might be helpful to enclose a copy of a policy from one of our hospitals, demonstrating our commitment to the well being of this specific patient group.¹ These are consistent with HQS standard 28, Children's Service standards, to which all of our Hospitals which admit children adhere.

Equally we recognise the limitation imposed by the relatively small number of children coming to our hospitals, in terms of the continuing experience of staff. For that reason, we do not generally undertake obstetrics work or, unless there are exceptional circumstances, admit children of less than one, and in certain cases two, years of age. One of our hospitals does however have an active obstetrics programme, with appropriate neonatal support and this is reflected in the figures below.

For your information admissions during 1998 of children were as follows:

<i>Age Range</i>	<i>Number of Admissions</i>
<i>0 to 5 years</i>	<i>3,139</i>
<i>6 to 10 years</i>	<i>2,515</i>
<i>11 to 15 years</i>	<i>2,477</i>

Complaints Policy Reference to Registering Health Authority (Q 383)

The point made in the hearing was a fair one and we will therefore, at the next re-issue of the policy, make clear that it is open to dissatisfied patients to direct their complaint to the registering health authority. For the sake of completeness I should add that this is already stated in the policy applicable to our psychiatric units.

Medical Advisory Committee Qualifications of Chairman (Q 344)

We have checked with each of our Hospitals and, as indicated at the hearing, they re-confirm that each MAC Chairman (and indeed his or her deputy, and all members) are medically qualified and each is a senior clinician of some years standing.

We have also looked very carefully at the HCSA Memorandum from which Dr Stoate quoted. Whilst the quotation is correctly given, the HCSA has been unable to give a detailed basis for the statement as to lack of a medical qualification but did venture the suggestion that it might have been advised of a dental practitioner once chairing a Medical Advisory Committee. However this is not something that has occurred at one of our units.

GP Referrals (Q 287)

We estimate that not less than 95 per cent of our total patients (admissions and out-patients) are referred by a GP. This does not include patients attending for health screening, or certain direct access out-patient services such as physiotherapy. I ought to add that all patients attending for cosmetic surgery are required to have a GP referral.

18 May 1999

¹Not Printed.

APPENDIX 56

Preliminary memorandum by the Department of Health (PM 77B)

Prior to the setting up of this inquiry, the Committee asked for a note on the regulation monitoring and inspection of private health provision. This memorandum set out the position at that time and address the key areas raised by the Committee.

ARRANGEMENTS FOR REGULATING, MONITORING AND CONTROLLING PRIVATE HEALTH PROVISION, INCLUDING COSMETIC SURGEONS, "WALK-IN DOCTORS" AND SLIMMING CLINICS AS IN JULY 1998

1. The regulation of independent (ie both private and voluntary) health provision is a responsibility of Health Authorities under Part II of the Registered Homes Act 1984. For the purposes of that Act, all regulated independent health establishments are classified as "nursing homes", and there is no statutory distinction between "true" nursing homes and those establishments providing more acute healthcare services. However, according to statistics collected by the Department of Health, there are 350 registered establishments (1995–96) in England with 10,600 beds which are described as independent hospitals and clinics (this compares with 5,540 nursing homes with 179,220 beds).

2. In addition, independent hospitals and nursing homes where abortions are performed are required by the Abortion Act to be approved separately by the Secretary of State.

3. Aside from nursing homes, the services covered by the Registered Homes Act 1984 include:

- independent acute hospitals;
- independent psychiatric hospitals (including those specialising in drug or alcohol abuse);
- hospices for the terminally ill;
- any premises (unless specifically excluded) where;
 - i. surgical procedures are carried out under general or local anaesthesia;
 - ii. pregnancies are terminated;
 - iii. endoscopy is carried out;
 - iv. haemodialysis or peritoneal dialysis is carried out;
 - v. specially controlled techniques (at present the use of Class 3B and Class 4 lasers) are used.

For the purposes of this memorandum, all private healthcare provision registered under Part II of the Registered Homes Act 1984 are defined as "establishments".

4. Health Authorities must, under Part II of the Registered Homes Act 1984, inspect each establishment at least twice a year and be satisfied that the statutory requirements and any local conditions of registration are met. Inspection may be out of hours and unannounced, with specialist staff drafted in where necessary. The primary concern of the registering authority is to ensure that the level of care provided is sufficient and suitable to meet the needs of individual patients. Health authorities base their inspections on non-statutory guidance issued by the National Association of Health Authorities and Trusts (NAHAT) in 1993. This covers a wide range of topics. Standards should at least be comparable to those in NHS establishments.

5. If an establishment fails to comply with any of the statutory requirements or local conditions, health authorities have the power to cancel or refuse registration under the Act, which specifies the grounds for this action—for example, if the person responsible for the establishment or any employee is not a fit person; that the premises are not suitable; the establishment is used for improper or undesirable purposes; or the staffing is inappropriate. This applies to all registered establishments. If a registration is either refused or cancelled, or if the health authority imposes any conditions which the establishment's owner feels are unreasonable, he has a right under section 34 of the Registered Homes Act 1984 to appeal to a Registered Homes Tribunal. The Tribunal's decisions are legally binding. If the owner does make such an appeal, then the health authority's decision to cancel the registration does not take effect until the appeal has been heard.

6. In an emergency, closure powers are also available through application to a magistrate. Where an emergency closure procedure is used the owner may appeal to a Tribunal but closure takes effect immediately and the establishment stays closed pending appeal.

Regulation and Evaluation

7. The Department and Health Authorities have no powers to regulate or evaluate individual procedures in private establishments; however, nurses and doctors in the private sector are subject to the same regulations as those in the NHS. They must be registered with the UKCC or GMC respectively: these organisations are charged with regulating their respective professions. At the end of the day, it is for those using these establishments and the management to ensure quality, and with the recent growth in private health provision, market forces and competition can only improve the services offered.

Access To Records

8. The Access to Health Records Act 1990 applies as much to the independent sector as it does to the NHS. Regulation 7 of the Nursing Homes and Mental Nursing Homes Regulations 1984 requires the hospital to keep a register of surgical operations performed. However, this requires the hospital to keep the register for one year only after the last entry is made in it, and it need contain only the name of the medical practitioner who performed the operation and the name of the anaesthetist present.

9. There is no legal obligation on private hospitals to investigate complaints about the practice of attending physicians and surgeons, but they should offer general advice to patients on how to initiate such a complaint. A complaint about private medical treatment is primarily a matter for the patient with the practitioner or others concerned. It is open to individuals to seek redress through the courts or to bring the matter to the attention of the General Medical Council at 44 Hallam Street, London W1N 6AE.

CONSULTATION ON CHANGES TO INSPECTION PROCEDURES

10. The extensive consultation that took place on the regulation and inspection of social services (culminating in the 1996 Burgner Report) included the regulation of “those nursing homes which provide care (mostly long term or for respite purposes) of a kind which local authorities may be required to arrange under their community care responsibilities”. This consultation process did not therefore cover the regulation of the independent healthcare establishments referred to in this memorandum. The Government will shortly be issuing a White Paper on Social Services which will set out proposals for establishing independent regulation arrangements for social services and nursing homes, in line with its Manifesto commitment.

11. Changes to the arrangements for regulating nursing homes will affect the arrangements set out above for regulating independent healthcare provision. The Government intends to consult widely on the most appropriate arrangements for such regulation following publication of the Social Services White Paper.

CORPORATE AFFAIRS—OPERATIONAL POLICY UNIT

July 1998

APPENDIX 57

Memorandum by Mr Chris Vellenoweth

THE REGULATION OF HEALTH CARE OUTSIDE THE NHS (PM 118)

1. INTRODUCTION

The regulation of health care in independent hospitals and other premises is governed by the provisions of the Registered Homes Act 1984 (the Act). This note is concerned with acute hospitals and services.

This Act places the responsibility on the Secretary of State for Health to receive applications of persons to be registered and, if satisfied, to register them in respect of premises to be used for the reception of, and the provision of nursing for, persons suffering from any sickness, injury or infirmity.

In relation to “acute” services, the Act includes provisions specifically for:

The carrying out of surgical procedures under anaesthesia;

The termination of pregnancies;

Endoscopy;

Haemodialysis or peritoneal dialysis;

Treatment by specially controlled techniques.

Specially controlled techniques are those designated by the Secretary of State for Health as “subject to control any technique of medicine or surgery (including cosmetic surgery) as to which he is satisfied that its use may create a hazard for persons treated by means of it or for the staff of any premises where the technique is used” (Section 21(4)). To date only one technique has been so designated—the use of lasers beyond a defined power level.

The duties of the Secretary of State under the Act are delegated to health authorities in England and Wales. Inspection of registered premises are required to be carried out not less than twice a year.

Premises not requiring regulation are specified in the Act and are primarily those controlled by a Government department, or any other authority or body instituted by special Act of Parliament or incorporated by the Royal Charter; first aid rooms; medical practitioners consulting rooms; dentists and chiropodists surgeries; occupational health facilities; premises used wholly or mainly as a private dwelling. Whilst there is provision for the Secretary of State to exempt other premises, to date none has been and the controlled technique laser provisions do apply to most premises otherwise exempt from the Act provisions.

The Department of Health has issued, from time to time, guidance on these regulatory functions and the NHS Confederation issued in 1993 comprehensive guidance commended to health authorities by the Minister concerned.

The person registered is identified on the certificate of registration and is responsible for ensuring that the statutory requirements of Act, regulation and local conditions are followed. No qualifications are required and the person registered can be an individual or a corporate body.

The person in charge is responsible for the day to day running of the premises registered and for the overall responsibility for the care of patients. This person must be either a registered medical practitioner, a registered first level nurse or, in the case of a maternity home, a registered midwife.

The Act does not define “nursing”. “Adequacy” defined in the Act as “sufficient and suitable” is the most usually required test of acceptability for initial and continued registration.

2. RANGE OF PROVISION

There are some 11,200 beds for acute medicine and surgery in 230 independent hospitals and 64 hospitals with 1,950 beds for the treatment of acute mental illness and substance abuse, although some of these are dedicated units within general hospitals. Psychiatric re-habilitation, and non-acute mental illness services also relate to mental nursing homes categories in which there are some 28,000 beds.

Beyond the independent acute general and psychiatric hospitals is a wide and diffused number of specialist clinical services. For example in-vitro fertilisation, organ transplant, termination of pregnancy and radiation protection have additional regulatory mechanisms governed by specific statutes, whilst cosmetic surgery, techniques such as liposuction, hair transplants, some single specialty surgical procedures are examples of procedures which, questionably, are outside the scope of the Act. Recent developments in private primary care are outside the provisions of the Act as are such therapies as hyperbaric oxygen and alternative medicine practice.

Health authorities generally consider that the term “invasive procedures” captures the point at which the question arises whether the identified procedures should be drawn into a requirement to register. There is uncertainty as to the boundary. Although the Act specifies certain procedures, it makes no distinction, for example, between general and local anaesthesia.

Private patient beds in NHS hospitals are outside the provisions of the Act whilst those which are located within NHS sites but operated by independent companies are within the scope of the Act.

Local authorities regulate nursing agencies, which provide significant numbers of qualified nurses and other skilled support to the independent health care sector as well as to the NHS. This legislation is well out of date.

3. CASE FOR REVIEW

The Registered Homes Act has its roots in the Nursing Homes Act of 1927. Whilst the legislation has been reviewed, amended and consolidated from time to time, there has not been a radical review, other than in its relationship to social care, the result of which is the proposals in the Government White Paper for the modernisation of social services. The Act covers the whole spectrum of registered homes—residential and nursing with provision for dual registration. Acute hospitals are, for the purposes of legislation, registered homes.

The time for the Health Committee inquiry is opportune not least because the Government, in its White Paper on Social Services, has acknowledged the work of Tom Burgner which identified a strong consensus for change in the regulation of non-acute nursing and residential homes. The White Paper says that the Government is considering how best to deal with the regulation of the independent acute health care sector, of independent mental health hospitals and of nursing agencies, to see what improvements can be made to the current system.

Acute independent hospitals and services are an important but, for most health authorities, a quantitatively minor component of the work of their regulatory units. It is unlikely that it would be cost effective or even manageable for every health authority to continue to regulate, in its present form, such health care provision outside the NHS once the changes proposed in the Social Services White Paper are implemented. The consequences of lifting the regulation of non-acute nursing homes away from health authorities have such an impact that it is appropriate that decisions relating to all sectors of independent health care provision are dovetailed.

4. SCOPE

Any review of the provision of health care outside the NHS should clarify the range of services to be brought within the scope of regulation.

Consideration might therefore be given to:

Services provided

- Acute surgical and related support services such as theatres, anaesthetic provision, recovery rooms, intensive care and associated support services;
- Acute medical services;
- Diagnostic facilities;
- Laser clinics;
- Hyperbaric facilities;
- Cosmetic surgery;
- Developing services, eg disease management programmes;
- Mental health facilities with particular reference to acute psychiatric hospitals and the related provisions of mental health legislation;
- Hospices;
- Complementary and alternative medicine.

Internal governance

- Management;
- Clinician appointments;
- Fitness for purpose.

External relationships

Clinical/Patient care:

- NHS clinical support agreements (eg intensive care);
- Human Fertilisation & Embryology Authority;
- UK Transplant Support Services Authority;
- Radiation Protection Board;
- Local authority statutory duties (eg nursing agencies);
- Department of Health (operation of the Abortion Act).

Non clinical:

- Better Regulation Unit—Cabinet office;
- Office of Fair Trading;
- Health & Safety Executive;
- Local authority—(Environmental health);
- Fire authorities.

Services currently exempt from the provisions of the Registered Homes Act:

- Fee bearing practice within the NHS at primary and secondary care level;
- Other services identified during review.

Practice issues:

- Operational policies and protocols;
- Staffing—recruitment, competences and cover;
- Management of complaints.

Organisation:

- Examination of the Registered Homes Act and supporting regulations;
- Review of exemptions and operation of and potential of the special techniques provisions;
- The impact of the NHS reforms;
- The impact of the Social Services White Paper proposals;

- Developments in regulatory policy and practice; competences of regulation;
- The relationships between regulation, and quality assurance including clinical governance;
- The influence of purchasers and insurers on standards;
- Options for regulatory mechanisms.

March 1999

APPENDIX 58

Letter from the Parliamentary Clerk, Department of Health to the Clerk of the Committee

REGULATION OF THE PRIVATE SECTOR (PM 77C)

You wrote on 28 May raising a number of issues about the position of patients admitted to NHS private patient beds and units.

The Department has not issued any recent guidance to the NHS on the management of private patient beds or units but the general principles are set out in the booklet *Management of Private Practice in Health Service Hospitals in England and Wales* (the Green Book) a copy of which is enclosed.¹ While the legislation on which it is based—the NHS Act 1977—has been amended or superseded by other legislation the general principle, that the provision of accommodation and services for private patients must not significantly interfere with Trusts' duties towards NHS patients, remains unaltered. It is also of course important that a Trust providing paybeds at least recovers its costs. I should add that while your letter is concerned primarily with private patient units the Department, in its guidance, has not sought to distinguish between dedicated units and other paybeds—our concern is with the management of private work in the NHS wherever it is undertaken.

You raised a number of specific issues. First, it is a matter of local discretion as to how admission policies are decided and this would very much depend on the arrangements which are agreed locally for operating private practice arrangements in a particular unit.

Second, we have not set any national policy on the use of equipment housed in a private patient unit and this will vary depending on local arrangements.

Third, again there is no Departmental policy about procedures being undertaken in private patient units which are not undertaken more generally in a hospital. Rather these are issues for local operational management.

In all these areas the Committee may find it helpful to investigate what happens in some NHS Trusts which operate private practice units.

Fourth, the NHS complaints procedure exists to deal with complaints by NHS patients about NHS treatment and services. The general position is that where a patient is using a paybed the patient can use the NHS complaints procedure for any complaint about a Trust's staff and facilities but not in relation to the private medical care provided by the consultant outside his or her NHS contract. However in some of the circumstances you describe—for example where a unit is operated by a private company on behalf of the Trust, is self-contained and does not use NHS staff—then it is doubtful whether the NHS complaints procedure as such would apply. In such circumstances the Trust should of course ensure that there are proper procedures in place for dealing with complaints. Again the Committee might find it helpful to establish how complaints are dealt with in practice in these circumstances.

Finally, the Community Health Council Regulations 1996 permit a Council to enter and inspect "any premises controlled by a relevant Health Authority or relevant NHS Trust". They do not define control more precisely and I think there would need to be case by case consideration of whether a trust controls particular premises to determine right of access. That said, the underlying aim of the regulations is to ensure that CHCs can carry out their role of representing the interests of the public locally when they use NHS services. They do not have a remit in respect of private patients receiving non-NHS treatment but they would have, or could agree, rights of access where an NHS patient was being treated in a private unit.

9 June 1999

APPENDIX 59

Letter from Mrs Elaine Isaacs to the Clerk of the Committees (PM 35)

Thank you for your letter of 17 December 1998. I understand the Inquiry is open for individuals to submit evidence to the Committee. The enclosed Appendix Sheet, copy letters, and incident sheet give insight into my late husband's psychiatric condition and events which covered a five month period and ended with his tragic death on 26 February 1987 when he was found hanging at home.¹

¹ Not printed.

Highlighted is the NHS Complaints Procedure versus no complaints procedures being available for Private Healthcare. As a voluntary psychiatrist patient, my late husband's NHS inpatient care consisted of six nights between three hospitals. Private inpatient care consisted of 27 nights. He was seen by a private consultant on 22 occasions including a domiciliary visit and discharge (at my late husband's own request).

From the complexities of our case, when turning to the Community Health Councils, they were able to assist, criticise, raise awareness and monitor for change and improvement, as is highlighted (see Appendix Sheet). However, there is no remit to cover the treatment which had been provided by private health care (see Appendix Sheet).

Had my husband been under a section of the Mental Health Act, whether a NHS or private patient, he would not only have redress to the Mental Health Act Commission, he would have had the benefit of the NHS Complaints Procedure and, as a private patient, to NHS guidelines which are followed for complaints. As a voluntary patient, the complaints procedure was only available under the NHS and there is no redress via the Mental Health Act Commission. As a private voluntary patient he did not have access to Mental Health Act Commissioners and there is no complaints procedures for Private Healthcare.

I would like to bring the following to your attention: When the Consultant visited our home we were given the choice of Private or NHS inpatient care, under the same consultant. For effective monitoring of standards for all patients, it is vital that private care and treatment is as accountable as NHS treatment, whether the consultant is working in private and/or NHS facilities.

Please see Appendix A. At this particular time the staff of Hollybank Nursing Home were unable to contact the private consultant.

In the majority of psychiatric cases, a patient in the first instance would be taken to an NHS Casualty Department, usually via a 999 call. If they then subsequently, as in our case, go into Private Healthcare, any complaint or investigation cannot be looked at in its entirety under the current unacceptable procedure, to the detriment of the complainant or to the person pursuing any claim.

Please note, legal action was not continued in our case.

11 January 1999

Published by The Stationery Office Limited

and available from:

The Publications Centre

(Mail, telephone and fax orders only)

PO Box 276, London SW8 5DT

General enquiries *Lo-call* 0345 58 54 63

Order through the Parliamentary Hotline *Lo-call* 0345 02 34 74

Fax orders 0171 873 8200

The Stationery Office Bookshops

123 Kingsway, London WC2B 6PQ

0171 242 6393 Fax 0171 242 6394

68–69 Bull Street, Birmingham B4 6AD

0121 236 9696 Fax 0121 236 9699

33 Wine Street, Bristol BS1 2BQ

0117 9264306 Fax 0117 9294515

9–21 Princess Street, Manchester M60 8AS

0161 834 7201 Fax 0161 833 0634

16 Arthur Street, Belfast BT1 4GD

01232 238451 Fax 01232 235401

The Stationery Office Oriel Bookshop

18–19 High Street, Cardiff CF1 2BZ

01222 395548 Fax 01222 384347

71 Lothian Road, Edinburgh EH3 9AZ

0870 606 55 66 Fax 0870 606 55 88

The Parliamentary Bookshop

12 Bridge Street, Parliament Square

London SW1A 2JX

Telephone orders 0171 219 3890

General enquiries 0171 219 3890

Fax orders 0171 219 3866

Accredited Agents

(see Yellow Pages)

and through good booksellers

© *Parliamentary Copyright House of Commons* 1999

Applications for reproduction should be made in writing to the Copyright Unit,

Her Majesty's Stationery Office, St Clements House, 2–16 Colegate, Norwich NR3 1BQ

– Fax 01603 723000

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd., which is responsible for printing and publishing House publications

ISBN 0 10 556264 5